Supreme Court, U. S.
FILED
AUG 15 1977
MICHAEL RODAK, JR., CLERK

VOLUME II—Pages 352-717
APPENDIX

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPEAL DOCKETED MAY 21, 1976
JURISDICTION NOTED MAY 31, 1977

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IN THE

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Appellants,

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J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR LAWSON H. BOWLING, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signature of the witness was specifically waived by his attorney of record, Ms. Dorothy Y. Kirkley, Esq.)

[3]

LAWSON H. BOWLING, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your name for the record, please?

A Lawson H. Bowling, M.D.

Q And where are you employed, Doctor Bowling?

A I am the superintendent of the Georgia Regional Hospital at Atlanta.

NOTE: (Defendant's Exhibit Number One was marked for purposes of identification.)

Q Would you identify Exhibit One? Just state what that is, please, Doctor? Just state what that is.

A This is a curriculum vitae on myself.

Q And how long have you been superintendent at Atlanta Regional, Doctor?

A Since May of 1968.

NOTE: (Defendant's Exhibit Number Two was marked for purposes of identification.)

[3]

Q Now if you would just identify briefly Exhibit Two and its component parts, then we'll go back into each of them in some more detail later in your testimony.

A All right. This is a looseleaf notebook which contains the following lists by patient number of the children admitted—of the persons admitted age seventeen and under to the Georgia Regional Hospital of Atlanta since January 1, 1969. It shows the diagnosis made on these persons and whether they were voluntary or involuntary patients. It shows the date the person was separated from

the hospital, whether they were on convalescent leave, and it shows the discharge date and to whom they were released. It also contains a list by initials of children who were denied voluntary admissions, including referral to the Comprehensive Community Mental Health Centers in the hospital's service area. It contains written policy and procedure of the childrens—child and adolescent program for periodic review of patient cases. It contains the written admission policies of the child and adolescent program, and it contains the hospital's policies and procedures for periodic review of patients by the hospital's quality review committee, which is a committee of the medical staff, and this is commonly called a utilization review in which the committee undertakes to see if the utilization of the bed is proper, that is if the person occupying that bed should be occupying it.

Q Okay. Let's go back for a minute to the first thing, the itemized list of patients.

[4]

A All right.

Q We were discussing that off the record a minute ago, and we determined, did we not, these were done manually and they're not in any particular order according to date or patient number?

A That's correct.

Q Who prepared that summary, Doctor?

A That—that summary was prepared by the staff of the Patient Affairs and Records section of the Atlanta Regional Hospital.

Q Could you describe, please, what your role and duties are as the superintendent of the hospital?

A Yes, as superintendent of the hospital, I am directly responsible for the entire operation of the hospital, for its administration and for the treatment programs and for establishing policies and procedures for the proper operation of the hospital.

Q Okay. What counties does Georgia Regional Hospital at Atlanta serve?

A It serves Cobb County, Douglas, Fulton, Clayton, and the central and south services areas of Dekalb County.

Q Are there also community mental health programs within this area?

A In that area there are nine established and operating comprehensive community mental health centers.

Q Do they have satellite offices, also?

A Some of them do.

Q And what is your relationship with the community mental health centers?

A We have written agreements with each of these centers as to [5] the function of the center and the function of the hospital. The basic philosophy of those agreements is that—which is the basic philosophy of the hospital, is that persons will be treated in the comprehensive community mental health centers in every possible instance, rather than being hospitalized. The hospital's philosophy on hospitalization—this applies to all patients, including the children and adolescent patients, is that hospitalization is to be carried out only when the person is, by reason of mental illness, unable to control his behavior, or constitutes—by that—for that reason, a threat to his and other person's physical safety, when all alternatives to hospitalization have been exhausted, and discharge

planning is begun upon admission. I'd like to add a statement of fact to that, and that is that the hospital has been critized in the public media for not admitting patients. We've had statements come out in the press that the patients who are taken to the Atlanta Regional Hospital often beat the person back home that took them. The hospital's philosophy, then, is not to admit unless it is required for stabilization of out of control behavior and dangerous behavior. I'm talking about admitting—well, that is essentially the basic philosophy. We handle voluntary or involuntary applicants in a similar manner, and then relating to the comprehensive mental health centers —well, the basic policy of the hospital is to either admit to a bed or find a suitable alternate, and we seek out a suitable alternate to hospitalization in every possible instance, and the comprehensive community mental health centers that I mentioned, are [6] principle places that we make referrals to—if a person is not requiring hospitalization.

Q What are you—just in your own words, what are your policies with regards to admissions, and—with specific reference to the admission of children and adolescents?

A That they're admitted only when their behavior is unstable and out of control and constituting a danger to themselves or others.

Q What process would they go through to get admitted?

A When any contact is made with the hospital to admit a child, and this is true, also, with most adolescents, they are referred to their comprehensive community mental health center initially. The purpose of that is to

try all non-hospital alternatives first. The primary source of such patients is the—are the county departments of family and children services, and we have established relationships with them in such a way that when they have a potential—when they have a disturbed child before them, they—the Departments of Family and Children Services contact the comprehensive community mental health centers first, before calling us. We have that understanding with them. The purpose of that is to try to ensure inappropriate hospitalization does not occur.

Q Are there ever situations where a child would not go first to the community mental health clinic?

A Yes. Yes. I would like to add first before I answer that, that not all comprehensive community mental health center referrals are admitted, because the hospital has a screening procedure, even after they are referred to us from the mental [7] health centers, and the estimate as to how many of those are turned back is approximatel twenty-five percent.

Q Excuse me, that's even from the community mental health clinics?

A Even from the community mental health centers. We do have direct calls, and when that call comes to the hospital—I do have a document here that gives a rundown or those kinds of contacts as from January the 22nd, '75 up until the present time. It just covers that one-time period.

NOTE: (Defendant's Exhibit Three was marked for purposes of identification.)

A Then the hospital's childrens programs screening procedure is carried out, of which there is a copy of that written procedure in this looseleaf notebook under the tab

that's called admission policies and procedures. That procedure is carried out—the purpose of that is to make doubly sure that inappropriate hospitalization does not occur.

Q Who would be involved in that screening process at the hospital?

A The staff of the childrens unit. Then the kinds of persons that are involved in that are called screening coordinators, who are appointed by the program director of the child—of the children's service, and it includes these kinds of personnel, social workers, psychologists, an assistant director of education and a psychiatrist.

Q And this procedure is done after a referral is made but before the hospital—the child is admitted to the hospital?

A That's done before the child is ever admitted to the hospital.

Q You stated a minute ago what your philosophy was and what some of the criteria were for admitting people to the hospital, [8] that is if they were dangerous to themselves or others. Do you use that standard for children?

A Yes, we do. Dangerous to themselves or others, or behavior that is out of control.

Q Do you have any policies with regard to the joint treatment of a family while a child is in the hospital?

A It's standard procedure in the children's program to immediately involve the available—the parents in the treatment process.

Q Are you aware in any percentage of cases, of reluctance of parents to become involved in the treatment program?

A I don't know a percentage. There are a certain number, that it is difficult for us to get them and keep them involved.

Q Would you say that that would be—in ballpark, say a quarter of the time, ten percent of the time . . .

A No, I'd just guess that it would be ten percent. Twenty-five percent or less. The majority of the parents cooperate on that.

Q And that treatment program would be carried out for the family by the community mental health centers?

A Not necessarily. It's—I would say primarily, on the hospitalized children, it's done by our own staff, but it may be done by the community mental health centers.

Q Once a child is in the hospital, are there any procedures for reviewing his case?

A Yes, and these are set forth in this looseleaf notebook in the form of copies of those standing official hospital and children's program policies and procedures. One is entitled "Rounds", which is a regular meeting of the staff which takes [9] place once each week, in which they take a reading on the situation, the progress, and what is known as the "Staffing procedure", which involves—which involves a number of things. It involves an initial assessment of the problem, the formulation of the treatment plan, and—that is carried out—that is followed up by the regular rounds at which that is reviewed.

Q How often does one of these reviews occur, is there a stated time?

A There's a review of each case once a week.

Q By the—this policy on staffing procedures?

A Staffing procedure is done on the initial admission primarily to formulate a treatment plan for the patient, and there's a third part of that policy which is called "Termination conference", which takes place about the time the staff is of the opinion that the person—the child should be discharged.

Q Do you know how many in-patients you currently have on the children's unit?

A Yes, there are fourteen.

Q Does that include adolescents?

A No, it does not include adolescents.

Q Do you have a separate adolescent unit?

A We do not. The adolescent patients are admitted to the adult units, which are based on a geographic service area. They—there is an in-hospital day treatment program for adolescents.

Q How many adolescents are there currently in the hospital?

A I don't have that number. Yes, I'm sorry, I do have it. [10] The current in-patients, adolescents, twenty-two, and I gave the wrong number earlier for children. I said fourteen, it's seventeen, so that there are a total of thirty-nine adolescents and children combined.

Q What is the day treatment that you spoke of for adolescents?

A That is a treatment of activities, group therapy, which takes place during the hours of approximately eight A.M. until four-thirty P.M.

Q Is part of that a school program for the adolescents?

A Part of that is school, yes it is.

Q You spoke about geographic units. You mean like each county in your area is represented in your hospital by a ward?

A Yes, it is. There are one or more buildings in the hospital whose staff in that building are designated for patients from the—from these several counties that we mentioned earlier.

Q Is there a separate unit for each county that you mentioned?

A Some counties have one unit, there is one—and others have two. That has to do with the numbers of the patients that are admitted from the different areas because there are more people in some counties than others.

Q Okay. And the adolescents would be disbursed among those different units?

A They are, as far as their—as to where their treatments plans are formulated, they are formulated by the staffs of those geographic units, and the patients—and the adolescent patients live in those units, that geographic area.

Q But during the day they're all brought together?

A They are all brought together during the day in that day program.

[11]

Q Do you have any idea what the current average length of stay is for the children and the adolescents?

A I'm sorry, I don't.

Q Okay. You also spoke about a utilization review plan, and that's different, is it not, from the staffings and the rounds conducted . . .

A Yes, it is. That is outlined in the looseleaf notebook. That is a overall hospital policy and procedure which is part of the proceedings of the quality review committee of the medical staff, which—which committee is appointed by the president of the medical staff, who is appointed by me.

Q And how often would this utilization review occur?

A It occurs—they meet monthly to review utilization of beds in the entire hospital, including children and adolescents.

Q Would they review each case every month?

A No, they do not. They review a representative sample of cases. They would not review every case in the hospital every month.

NOTE: (Defendant's Exhibit Number Four was marked for purposes of identification.)

Q Would you identify that Exhibit, please?

A These are the admission documents and admission instruments on all patients who are currently resident patients at the Atlanta Regional Hospital, and it includes data regarding their social history. That's what it is.

Q And that's for each child who is presently a patient . . .

A That's for each child and adolescent who is presently a patient in the hospital.

[12]

Q Does this include social summaries?

A It's supposed to include the social data that we have. We do not collect a specific document that is called

social history. That—we have a data base that's collected on every patient and that includes social information, plus additional notes that may be made by social workers who are working on a particular case, and in instances where that was the case, that was attached to these individual admission instruments.

Q Would this include information gathered by the community mental health program if someone had been through a community program?

A It would include—yes, it would, although it would not be in the form of a document submitted from the center. It would include information that they may have obtained prior to the person's admission.

Q You were talking a bit ago about a screening committee even after a referral had been made by a mental health clinic, is that right?

A Yes, the screening procedure that's outlined in this written policy and procedure in this booklet is carried out, even on those patients who are referred by the community mental health centers before a final decision is made to actually admit the person.

Q Well, when . . .

A I'm talking about pre-adolescent children. I'm not talking about adolescents. They're handled by—in the same manner that adults are in those adult units.

Q Okay. In this screening process, does the screening committee [13] have additional information from the community mental health clinics like prior treatments and psychological examinations and psychiatric interviews?

A They do have additional information, and some of which may—some of which may be in writing, and some of which may have been obtained by them directly over the phone.

Q So the information in Exhibit Three would not necessarily be all the information upon which an admission decision was made?

A Wouldn't necessarily be all of it, that's right.

Q In this screening process, is another psychiatric interview conducted by the admitting physician?

A The pre-adolescent children—the pre-adolescent childrens unit has a psychiatrist who participates in the admission procedure, and he—he interviews—he at least sees personally—I'm sorry, that's not correct. He does not necessarily see the patient in person each time before he is admitted, but he makes the decision as to whether a person shall be admitted or not. That's done by the physician—by the psychiatrist. And the same is true of the adolescents in those adult units. All patients are admitted to the hospital on the decision of the hospital physician.

Q But you're saying it wouldn't necessarily be on the basis of a psychiatric interview by the admitting psychiatrist?

A Not necessarily.

Q Would admission be preceded by a psychiatric interview by a psychiatrist at the mental health clinic?

A I don't specifically have that knowledge.

Q Okay. Do you know of any problem with regard to parents who [14] are reluctant to take their children back home when your staff recommends discharge?

A I can't quantify that, but there are—there are problems in a certain number of cases.

Q Have you got an estimate as to what percentage of cases that might be?

A Twenty-five percent would be an estimate of that.

Q And how do you handle that reluctance, or that problem?

A The staff works intensively with those parents on a continuing basis, and where that's a problem, they address that as a problem, and if they're absolutely unable to place the parent—the child with the parents, or if it is determined by the psychiatrist that it would be undesirable for that child to be—in the interest of his mental health, that he be placed with those parents, then we seek an alternate foster home type placement in collaboration with the county Departments of Family and Childrens Services. I might say that on occasion our staff has—has sought out a foster home themselves, gotten the county Family and Childrens Services to certify that home as being proper to receive a child, and that was done in one instance just recently, a child in Fulton County, who had been in the hospital for two years. The staff sought out a foster home and that child was placed in that home just before Thanksgiving of this year.

Q But the resource you would use primarily for that would be the county Department of Family and Childrens Services?

A That's the primary resource we use to place those children.

Q And then sometimes—do they go into juvenile court to remove [15] custody from the parents?

A That happens in some instances, yes. By the way, I'm not sure about that child I mentioned, but a certain number of these children have no natural parental figures, so that we—we seek out surrogate parental figures, and family—home settings.

Q One of the contentions in this case, Doctor, is that there is a necessity for judicial proceedings in juvenile court prior to the admission of children to the hospital. As superintendent, do you believe that such proceedings are necessary?

A I happen to be of the opinion that they are not necessary, that there are many mechanisms to protect a child from, shall we say, just being thrown into a mental hospital. I've described a number of them, and how we do it at Atlanta Regional Hospital, how we undertake to do it. I—it's my opinion that where mental illness exists, that physicians and staffs of community mental health centers are trained and experienced in recognizing those conditions, and that the subjecting of a mentally ill child to a courtroom procedure, could be detrimental to his—could cause him anxieties and tensions, fears, that in my opinion would not be necessary.

Q That's all the questions I have.

EXAMINATION BY MR. GOREN:

Q Doctor Bowling, I'd like to ask you, initially, about the relationship with community health centers. Could you describe how they might get a referral and how that would lead someone to coming to your institution?

A Yes, I—you understand that I do not work directly with [16] them in those centers, but the—they might get a referral from an adolescent either presenting himself at that center with a problem, a parent presenting an adolescent with a problem, or a parent presenting a child with a problem. They might get a referral from a family physician, pediatrician, they might get a referral from the department—county Department of Family and Childrens Services. I guess those are the principle ways that people might approach them wanting a service.

Q Do you know what criteria the community mental health centers use in deciding whether or not to refer kids to your hospital?

A As far as I know, because of the relationships that Mr. Baeszler, who is the director of the hospital's program has developed with these centers, it is essentially persons whose behavior is out of control and constitutes a physical danger to themselves and others, that's the primary criteria.

Q Is that the same criteria that your hospital uses?

A Yes.

Q Do you know on what basis the community mental health clinics arrive at that decision?

A I do not. I don't know how they reach that decision, other than, I presume, overt behaviors on the part of the child or adolescent.

Q Do you know how they get that information about that overt behavior?

A No, I don't. I don't know whether they get it by hearsay from other persons, or whether they actually observe it.

Q But however they arrive at the conclusion that a child or an [17] adolescent is exhibiting dangerous behavior or behavior that's out of control, they then would refer the case to your hospital?

A (No audible response.)

Q And specifically how would they do that?

A They would call the hospital childrens unit and state the problem, whereupon we would have them enter the child into our screening procedure which I tried to describe earlier, and which is outlined in this booklet.

Q You don't know if that child was first examined by a psychiatrist at the community clinic before the case was referred to your hospital?

A I do not specifically know that. I do know that those centers have psychiatrists. I do not know whether they specifically have an examination by a psychiatrist in each instance. I just don't know that.

Q Do you know if they are psychiatrists who work in the center, or are they consultant psychiatrists?

A My—I should think that in most instances they are consulting psychiatrists on a part-time basis. I don't know specifically of any of those centers that have a full-time child psychiatrist.

Q You also mentioned that you believe that your hospital rejects about twenty-five percent of the referrals from the community clinics?

A Yes.

Q Do you know what percent the community clinics themselves reject?

A I do not.

Q Okay. In the screening review at your hospital after a case is referred there, do you know exactly what that screening review [18] consists of?

A Well, it consists of—of everything that's outlined in this type of procedure. I don't know how do give you a capsule summary of that because the . . .

Q Well, how long would the screening procedure take before it's finalized and before a decision is made?

A Those—the decision is made at the—at the screening appointment, which is referred to in that policy procedure, and prior to that time there are considerable amounts of data gathered about the child, which is outlined in there, and I would say that the screening appointment and the actual procedure would consume about two to three hours on the average.

Q Is it important to gather such data?

A To gather the data prior to that appointment? In my opinion it is.

Q Why is that?

A To—to obtain as much information as the staff can as to what has happened to that child in the past and what may have happened to him prior to him—as to the reason for referring him for hospitalization. The information, of course, is accepted from other persons. It's not a direct experience of the staff of the hospital.

Q How is this information verified by your screening procedure?

A It is accepted on the basis of any verbal information that's given, of the staff of the hospital knowing or accepting the statement of the person that they are talking to, that they are staff of the centers, and they—members of our staff spend a certain amount of time in these centers, so that [19] many times the persons know each other personally and know that they are on the staff of these treatment centers, and the written documents would usually bear the letterhead of the referring center.

Q Who would you believe would be the primary source of information when a child or adolescent is to be admitted to your facility?

A Who would be the primary source of information?

Q Yes.

A You mean as to who—as to who would be the person that would best be interviewed?

Q Right.

A I would say that probably the child's parents or parent surrogates, but not—wouldn't limit it to that. It should be—there should be additional information obtained from such persons as a family physician who may have made observations of the child in a professional manner.

Q In regard to the parents or the surrogate parents, you mentioned that with a certain percent of the cases, and I believe you used somewhere between ten percent and twenty-five percent, you noticed that parents were reluctant to participate in their responsibilities for their children, is that correct?

A That's what I said, yes.

Q Okay. Why do you think this might be?

A I think there can be a variety of reasons. It can be such things as the parents feel guilty about having a disturbed child. They may wish to have some professionals or other [20] persons to make this child different in his behaviors from what he is. They may feel guilt that they did not—that they did something wrong in rearing this child. Those would be the principle reasons that I think they might be reluctant. It's possible that they might not

want the child. But all of those things would have to be determined on each individual case, on an individual basis, and that is what the staff is trained to do in their professional practice.

Q Sure. You mentioned that one of the keystones is involving the family itself in treatment?

A That is axiomatic in the treatment of children, is to treat the parents and the child. It's considered to be a constellation of disturbance that exists, that where there is a mentally or emotionally disturbed child, that it relates to the parents.

Q And therefore the parents themselves require treatment?

A Yes, they do, they require—the parents and the child are all treated in the treatment plan for the child.

Q Because of these kinds of situations, is it possible that parents may misperceive or misinterpret or distort facts when they are asked information about their children?

A Yes, that's possible.

* * * * *

[22]

* * * * *

Q But one of the things you said, I believe, was that it's often difficult to get parents to volunteer some information. An example that might come to mind is, if the child—excuse me, if the parent had a record of child abuse, do you think that would be information that they would readily make available to the screening . . .

[23]

A I would say they'd be more likely not to readily make that available than they would but there would be

a certain number of them that might volunteer that information.

Q And for those who wouldn't, would it be helpful in making your decision to hospitalize if a court could discover that information and make it available?

A If that information were available to the staff, it would enrich their data base, in making their decision.

Q Okay. When you were describing the admission procedure, I don't know if I misunderstood you or not, but is a child, before he's admitted to your hospital, always examined by a psychiatrist at your hospital?

A He is always examined within twenty-four hours after admission. The psychiatrist may decide to admit based on the findings of the screening procedure, without necessarily directly examining that child. I would say that in most instances he actually does.

Q Would this be a . . .

A He definitely does it within twenty-four hours, which is the requirement of the Georgia law. The Atlanta Regional Hospital has a one-half-time child psychiatrist on the staff of this unit. The back-up to him is the psychiatric and other medical staff of the hospital.

Q Okay. You made a distinction before concerning—it seems like you make an important distinction between children and adolescents. At what age is the dividing line?

A The—what we call a pre-adolescent person is a person through the age of eleven, and an adolescent is a person age [24] twelve through sixteen. Those criteria were established by the Division of Mental Health of the Department of Human Resources.

Q Okay. How are pre-adolescents or children treated differently than adolescents?

A There is a separate building and staff for pre-adolescent children, and the adolescents are treated—I should say the—in both cases the treatment plans for these persons are developed—the treatment plan for the adolescents is developed in the geographic units. That is a major, essential difference in the way they're treated. In both instances—in the instance of both pre-adolescent and adolescent persons, there is a development of a specific written treatment plan for each individual, and in the—another difference is that in—although in the instance of both the pre-adolescents and adolescents efforts are made to work with the parents, that is intensely pursued with the pre-adolescent children. Those are the essential differences in the way these two groups are treated.

Q Is there a difference in admission procedures?

A There is a difference in the admission procedures.

Q What is that difference?

A The difference is that the adolescent patients are not—do not go through this elaborate screening procedure that the pre-adolescent patients go through.

Q Why would that be?

A The geographic units have—have their admission policies and procedures which are not—which do not include this [25] —this very elaborate screening procedure.

Q Why do you make the distinction between children and adolescents?

A Well, I suppose it's because that those units, being essentially adult units, they—there's never been a special admission procedure for the persons who are less than seventeen.

Q Okay. A child in the scheme at your hospital who reaches the age of twelve is considered an adolescent?

A Yes.

Q And a twelve-year-old would then be put on a geographic unit?

A That is the basic policy and practice. It is not followed in every instance because the staff on the preadolescent unit will sometimes retain a person a bit beyond that age limit in the interest of his treatment.

Q And on the geographic wards are adult patients? Say there might be situations where you would have a twelve-year-old on a unit with adult patients?

A Yes, that's correct.

Q What is it, in a child or adolescent which would make your hospital want to treat them so differently?

A That situation arose through a series of circumstances that goes back some years. The hospital never opened a separate unit for adolescents with a separate staff, and until 1973 the hospital did not receive and treat any adolescent patients. The—in 1973 the Division of Mental Health established a policy that all persons in the geographic area of the hospital would be treated, and we began to receive adolescent patients in the adult programs, and that's—that's how that situation, as it now exists, occurred.

[26]

NOTE: (Brief off the record.)

Q Doctor, we were discussing the difference in your hospital between how children and adolescents are treated, and you were describing that children are considered to be persons between—up until the age of eleven, and are considered adolescents from the age of twelve to sixteen.

A It's through eleven and from twelve to sixteen.

Q Okay. Is it your opinion, then, that adolescents are developed to the extent that they could function most properly on an adult ward?

A They—there is disagreement in psychiatry and in child psychiatry as to whether adolescents require a separate unit and a separate staff. There is no disagreement that each adolescent person requires a specific treatment plan, and that most professionals believe they should have a special treatment program, but that they do not have to live in a separate unit. Or they may or may not live in a separate unit, and they are—that is an issue that the experts will disagree on.

Q Okay. Did you say that you felt that a hearing that might be provided for a child, might have some detrimental effects on that child?

A I did say that.

Q Do you think those same effects would be present in an adolescent?

A Yes, I think they could be.

Q How about an adult?

A Let me modify my statement about adolescents to say that I [27] think it would be less so in an adolescent who had his personality more formed, and I would not equate the experience in the three groups. I'm giving you my opinion. My opinion would be that it could stimulate

—you might want to know in what way would I think it would be harmful. I think it would stimulate fantasies in a pre-adolescent child that he—that might would cause him to wonder what was going on or what might happen to him, and that—well, excuse me.

Q Wouldn't he also wonder what was happening, what was going on, when his parents take him to be admitted to the hospital and he finds himself—and he is accepted by the hospital and he finds himself in the hospital?

A Yes he would. Either procedure is a ritual or scenario which could stimulate fantasies that would produce—could produce anxiety or fear in the child.

Q Okay, but these wouldn't . . .

A Uncertainty.

Q These wouldn't necessarily be present in adolescents?

A I think they might be present—I think that they could be present, but that their impact on the person would more likely be less. The person could handle it better, so to speak. In a more realistic manner—handle it in a more realistic manner.

Q Okay. Do you know how many adolescents there are on the adult wards at Atlanta Regional?

A Yes, it would be the number that we have in the house at this time. Twenty-two.

[28]

Q I know it's hard to try to reach specific ages, but would a child or an adolescent at the age of twelve be able to handle a hearing without too much detrimental effect?

A I would not be able to set an arbitrary age on it, because there would be individual variations.

Q Okay. In other words, a twelve might—a particular twelve year old may be able to function fine, whereas one who would be older might have more problems?

A That's possible, because there's a tremendous variation among individual human beings.

Q Do you know if there are any twelve-year-olds on adult wards?

A Yeah. I don't specifically know that as of today, but there very well may be, and there certainly have been.

Q This policy for distinguishing between persons through the age of eleven and persons through the age of sixteen, is that a policy specifically of your hospital, or is that a state-wide policy?

A That is a policy of the Division of Mental Health of the Department of Human Resources. It's not a specific hospital policy.

Q Okay. Excuse me, you said it's not a specific hospital policy, but the entire . . .

A It is a policy of the Division of Mental Health of the Department of Human Resources. You asked if it was state-wide, that would make it state-wide.

Q It's your impression that all of the regional hospitals make this distinction?

A That's my understanding. I don't specifically know that to be [29] a fact, but that is my impression, yes.

Q Do you have any written policies from the division that spell out—making this distinction?

A I don't believe I have a written policy that spells that out.

Q But that policy was told to you?

A That policy was told to me by Doctor Charles Bush, who was the former Deputy Director of the Division of Mental Health.

Q And does the same policy . . .

A And it's never been rescinded. Excuse me.

Q Okay. Do the same distinctions between children and adolescents at the admission stage, come from policies that are also told to you to be state-wide?

A The—you mean in the procedures for admission?

Q Yes.

A Those procedures that I outlined to you are the procedures of the Atlanta Regional Hospital. I'm not aware of the specific procedures of the other hospitals.

Q Okay. Doctor, concerning the admissions of children, do you know the percentages—excuse me, let me ask first, is there a certain standard for diagnosis, a standard document that you refer to to make diagnosis?

A There is, and it's—it's the International Nomenclature of Disease, I believe is what it's called.

Q You do not use D.S.M.-2?

A Is that the—what is D.S.M.-2?

Q The Diagnostic and . . .

A Yes, yes, yes, we use that terminology that's listed n the Diagnostic and Statistical Manual of the American Psychiatric [30] Association, I believe, and that list is

contained within the International Nomenclature of Disease.

Q Okay, I see. Using those diagnostic categories, do you know which percentage—or what percentages of various categories that children who are voluntarily admitted to you hospital, fall under?

A I don't have that breakdown. I don't have that collated.

Q Do you have any idea as to—any approximation as to which category would be more prevalent than other categories?

A Yes, I would say that the--that the two—two most prevalent ones would be number one, schizophrenia, and number two would be behavior disorders of childhood and adolescence.

Q What would they include?

A Well, the Nomenclature has seven separate classes that come under that heading. Do you want me to name those off?

Q Only a few who would think that—some particular ones of those would be the most common in that category.

A I would say that probably the hyperkinetic reaction would be the most prevalent.

Q Okay. Upon admission, are children and/or adolescents informed of their rights as patients?

A They are.

Q How is that done?

A That is done by the admitting staff in the admitting process on a verbal basis to the child.

Q Are there any written policies, procedures describing how to effect this information?

[31]

A I don't believe we specifically have that. There are written policies and procedures in the hospital that—that do require staff to impart such information to all patients who are admitted.

Q And that would include children?

A That would include children and adolescents.

Q Are they given any written notice of these rights?

A The—each patient that's admitted to the hospital is given a copy of a booklet that is put out by the Division of Mental Health. It's called Your Rights Under Georgia's—in Georgia's Mental Health Facilities.

Q Is that written especially for children?

A No, it's not. It is written for—it is written for any patient admitted, but it is not written especially for children.

Q Okay. In your experience have you ever observed, say, an adolescent objecting to his confinement in the hospital?

A I can't cite you a specific instance, but we—he has every right to do so and there are written hospital policies and procedures as to what is to be done when a person does raise such objections. For instance, there is a right to apply for discharge, and there are written policies and procedures in all units in the hospital's manuals that are on all units, that spell out that procedure.

Q A child can do that also?

A I can't specifically tell you how that's handled. A child would have that right, but I can't tell you that we systematically practice that as a procedure.

[32]

Q As far as adolescents are concerned, do you know the procedures that are involved and how they would effectuate their rights?

A Yes, they can—they can say to any staff member at any time that they do not wish to be—that they wish to leave the hospital, and whereupon the standing policy and procedure is to be carried out. Now the essence of that is, that the person or his parent or guardian puts that in writing, and we actually have forms that they can use for that purpose, which the procedure calls for the staff making available to them, and then that document is dealt with so that the case physician reaches a decision as to whether, within a specified period of time, as to whether or not that discharge shall be granted, or whether the hospital shall take steps to prevent it.

Q Can that request for discharge only be done by the parent or guardian in the case of a voluntary admission of a juvenile?

A I believe that—that that's correct, because that is the—the way that we understand that the law is presently structured. Code Section 88-5 is what I'm talking about.

Q Okay. And this—and it's possible that this could be the same parent or guardian who you said might have a conflict of interest with the . . .

A That would be possible.

* * * * *

[36]

* * * * *

Q What would the effect be if there were, say, an advocate for the child or adolescent at these rounds or at the reviews that you [37] have, an advocate who would not be there to disrupt the proceedings, but just to speak on behalf of the patient?

A I would say no—no objections to that.

Q Okay.

A And it could be helpful.

Q In the same sense, do you think it might be helpful to have an opinion of someone who is outside of the system, someone who in the same sense could give a different perspective like an advocate . . .

A Well, that wouldn't hurt anything. That wouldn't hurt anything, and it could be helpful.

NOTE: (Brief off the record.)

Q Doctor, how many physicians do you have in your facility?

A We have eleven full-time and the half-time child psychiatrist.

Q Are these physicians board certified in psychiatry?

A There are three of us who are board certified, three out of the eleven who are certified in psychiatry.

Q And are all the others licensed to practice medicine?

A Yes, they are.

Q Are there any licensed only to practice in a state institution?

A There are two physicians who are licensed to practice only in the institution.

Q Are there any foreign born or trained physicians?

A Yes, there are.

Q How many are they?

A Four.

Q Do any of these physicians have difficulty with the English language?

[38]

A These particular ones do not with the exception of one, who has, I would say, minimal difficulty, in one physician whose primary language is Russian.

* * * * *

EXHIBIT 2

Screening Procedure

CHILD AND YOUTH SERVICES

January 20, 1975 Policy # 2, Part I

I. Referral taken by Screening Coordinator.

If coordinator is not available, the referral will be channeled to any one of the following team members.

A. Social Worker
B. Psychologist
C. Assistant director of Education
D. Psychiatrist

II. Phone Contact Sheet

During the referral (Initial contact) the team member taking referral will complete the Phone Contact Sheet.

Each team member will have xeroxed supply of Contact Sheets (sheet attached page # 1a).

Determine as soon as possible if the referral is appropriate (i.e., has been referred to GRHA by private psychiatrist or psychologist or has been through a mental health center). If referral is appropriate complete all questions on Phone Contact Sheet. If it is not a correct referral, supply person with name and phone number (see attached page 1B) of the mental health center in his area.

File original Phone Contact Sheet of those referred elsewhere in manila file folder located in secretary's file cabinet (drawer labeled "Screening"). The folder is labeled "Phone Contacts Referred".

Contact sheets of those not referred will be filed under "Phone Contacts—Appointment Scheduled." Location for this file will be the same file cabinet labeled "Screening".

III. Scheduling the screening appointment.

If the referral is appropriate, schedule a screening appointment at GRHA no sooner than four working days after date the contact call is received. The minimum four day period is to allow the screening team to gather all the information needed to assist in the disposition.

Record appointment date on blackboard and in the screening appointment book located at Ward Clerk's desk.

Xerox copies of contact sheet. Place one in each team member's communication mail box, place one in the folder established for child.

Folders to be established for each child scheduled for screening evaluation. The folders will be located in the same file cabinet as Phone Contact Sheets (drawer labeled "Screening").

After the screening appointment, the original phone contact sheet in folder labeled "Phone Contacts—Appointment Scheduled" will be (1) put in chart if child admitted, or (2) stapled to folder on child if child is referred elsewhere for treatment.

The team member taking the call is responsible for getting (1) contact sheet xeroxed, (2) getting copies of contact sheet to all other team members, (3) starting folder on child, (4) recording appointment on blackboard, (5) recording appointment in screening appointment book, and (6) putting original phone contact sheet in correct folder.

The screening team members are:

(1) Coordinator
(2) Social Worker
(3) Psychologist (alternate: Psychology Technician)
(4) Psychiatrist
(5) Assistant Director of Education (alternate: Teachers)

Each team member will be responsible for gathering certain information pertaining to their particular area.

IV. Assistant Director of Education: Information; responsibilities.

(1) Contact present or last school attended.
(2) Visit the school and observe the child in the classroom, if possible.
(3) If a visit to the school is not possible, contact the teacher by phone. Counselors or school social workers are alternates.
(4) If the school is closed (summer, holiday) contact area office, caseworker or parent for information.

Complete 1 page or less hand written xeroxed report of findings. Distribute copies to team members no later than 1 hour prior to screening appointment.

Put copy in child's folder.

Put copies of any reports received from schools, etc. in folder.

V. Psychologist: Responsibilities

(1) Contact the referring agency or doctor to determine testing information (extent of) available.
(2) Psychological tests will be administered if need is determined by the psychologist.

Criteria for testing:

(a) No testing available within last six months.
(b) Question as to validity or prior scores.
(c) Determine if child in in TMR, EMR range.
(d) Psychometric services not available at the community level.
(e) Question of LD problem.

(3) Possible need for condensed battery of tests. Though not as thorough as administering complete tests, the condensed version would give staff a general idea of where the child is functioning.
(4) Testing, etc. can be administered by the Psychology Technician.

If the Psychologist determines need for testing (by above criteria) and it is not available on the community level, the testing is to be completed during the four day period; (a) on one of the four days prior to the screening appointment, or (b) on the same day as the screening appointment.

Complete a one page or less handwritten report of findings. Xerox, distribute copies to team members prior to screening appointment.

Put copy in folder.

VI. Screening Coordinator.

(1) Receives phone contact.
(2) Schedules appointments.
(3) Periodically checks to see if appointments are:
  (a) on board
  (b) in notebook for appointments
  (c) folder established on child
  (d) phone contact sheets in correct location. Team members have xeroxed copies.
  (e) responsible for getting information from referring agency.
  (f) involve community mental health center in screening appointment; determine if representative from mental health center will be at screening appointment; coordinate involvement of community mental health centers and their contractual agreements with other agencies and staff member responsible for implementation of contractual agreements at GRHA.

VII. Social Worker/Social Work Technician

After taking phone contact or receiving notification of contact and appointment scheduled, the following items are to be completed:

(1) Make or coordinate home visit if possible.
(2) Gather as much information as possible on family. Get reports from DFCS, Juvenile Court, etc. if involved.
(3) See that agency representatives who attend screening are treated professionally.
(4) One page or less hand written report on family, social history. Distribute to team members no later than one hour prior to screening appointment.
(5) Xerox copies of information to child's folder.

VIII. Screening appointment.

(1) Thirty minutes before screening appointment the team members assemble to discuss findings Primary Therapist tentatively assigned at this point. If Primary Therapist is not team member, is notified to attend screening appointment.
(2) Client arrives and secretary assists parent or guardian in completing face sheet.
(3) Team members meet briefly with community mental health representative, caseworker, and other involved service workers.
(4) Client and parent or guardian (unless is above mentioned caseworker, etc) meet with team members and other agency representatives.
(5) Interview child with parent in room.
(6) Child, parent/guardian asked to remain in lobby while team members make disposition.
(7) Parent/guardian informed of disposition. If referred elsewhere, the name and phone number of referral agency is given to the parent. Dis-

position is discussed with mental health representative.

If admitted:

(1) Primary Therapist above assigned completes data base with parent's assistance.
(2) Secretary has parent/guardian complete all consent forms, other necessary paperwork.
(3) Parent meets with Social Work Technician to complete research forms.
(4) Staffing coordinator assigns staffing date.

If there are no beds available the child is placed on a holding list. Admission will be upon availability of a bed.

Final decision for admission will be with the consulting psychiatrist.

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

DEPOSITION OF

GLADELLE WHITAKER

Taken on behalf of the Defendants.

APPEARANCES:

For the Plaintiffs: MS. NANCY LINDBLOOM
Attorney at Law
Macon, Georgia

For the Plaintiffs: MR. GERALD R. TARUTIS
Attorney at Law
Macon, Georgia

For the Defendants: MR. DOUGLAS LACKEY
Attorney at Law
Atlanta, Georgia

[2]

This testimony came on to be heard in the District Office of the Department of Human Resources, located in Gainesville, Georgia, at approximately 3:00 p.m., December 4th, 1975.

MR. LACKEY: This is the deposition of MRS. GLADELLE WHITAKER, taken for the purpose of evidence in the matter of J.L. and J.R. versus Jim Parham, et al. The parties hereto have agreed to reserve all objections, except as to form.

(Signature of the witness is waived.)

GLADELLE WHITAKER,

being first duly sworn, was examined and deposed as follows:

EXAMINATION BY MR. LACKEY:

Q Would you state your name for the record?

A Gladelle Whitaker.

Q What is your address?

A 223 Lucille Lane, Toccoa, Georgia.

Q What is your occupation?

A Director for Stephens County Department of Family and Childrens Services.

MR. LACKEY: Council for the Plaintiffs and counsel for the Defendants stipulated that Mrs. Whitaker is the custodian of the file—(To the reporter.) Off the record.

(The parties went off the record for a brief [3] period of time.)

MR. LACKEY: Counsel for the Plaintiffs and counsel for the Defendants have stipulated that Mrs. Whitaker is the custodian of the record of Jimmy, a child, a minor child, who will be identified throughout this Hearing either as J.R. or Jimmy or James. We further stipulated that certain documents, which have been excerpted from that record, are true and correct copies of the documents contained in that record and that parties will stipulate that these documents are being included in the Court's records with this deposition, subject to the objections, which the Court has directed the parties to reserve. The documents themselves are broken down in

this fashion: There is one white folder of materials, which refer to the psychological examination given to the child; there is one white folder, which contains documents relating to placement attempts, attempts to place the child; one white folder, which relates to reports of the child's behavior in various foster homes and other situations; there is one group of documents, not in a white folder, which are the reports of the case worker assigned to Jimmy, beginning in December of 1974, and continuing through the present date; there is one set of documents, which constitute the Court order, the Petition, and supporting documents, which resulted in Jimmy's custody being given to the Stephens County Department of Family and Childrens Service. I don't know [4] how to identify the materials in the documents any more clearly than that, unless you have something you want to add.

MR. TARUTIS: You can say that counsel further agrees that these documents will not be attached to the deposition itself, but will be submitted under separate cover and will be numbered consecutively by counsel, jointly.

MR. LACKEY: We have stipulated that any objections to these documents will only be to their relevancy and not to their—and not to the form of admission. In other words the documents have been properly tendered, subject to your objections as relevancy.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

MR. TARUTIS: Councel further agrees that Mrs. Whitaker is the custodian of the documents, that the documents have been properly identified and placed into

evidence—have been properly identified and tendered for placement into evidence.

MR. LACKEY: Subject to your objections?

MR. TARUTIS: Right. Counsel has further agreed that Mrs. Whitaker is the custodian of these records and that these records have been properly identified and tendered into evidence, subject to the objections of Plaintiffs in this matter.

[5]

Q Mrs. Whitaker, you stated your position was County Director of the Department of Family and Childrens Services of Stephens County; how long have you been in this position?

A Seven and a half years.

Q Where were you employed before you became County Director?

A As a case worker with the Stephens County Family and Childrens Services.

Q How long were you in that position?

A Nine and a half years.

Q As County Director, what are your responsibilities particularly with respect to adoptions and foster care in the county?

A The Department of Family and Children Services has a responsibility for adoption, foster home placement, working with protective services for children, which includes abandoned children, children neglected or referred to us.

Q Without referring specifically to this case, can you tell us generally what the procedure is in Stephens County

for the placement for adoption or for foster care for children in your county?

A Children that are in custody of the department or who are voluntarily released to the department, are the ones we actively seek foster homes for or if we have permanent [6] custody—you would, you know, consider for adoption, if they are an adoptable child—we try to use for foster care a placement of an approved foster home within our own county. If it's an adoption, with permanent custody, we submit material to the District Office, which engages in finding the adopted home. We don't seek adoptive homes for specific children. Then getting back to the foster care in our own county, foster parents have the right to state what type of children, age range, etc., they can provide or care for in their own home. In the event that we have a home that is full or does not meet the needs of a specific child that needs placement, we come to our District Office stating that we have this child that needs foster care and that we do not have a home for him in our county, and would she explore the district foster homes. She keeps the central file here. A lot of information is not given to her, such as specifics in homes. They just make a referral that this home has a vacancy within this age range. We contact a worker in the other county giving them some background information, some information on the child, to see if maybe their foster parents where the vacancy occurs could take care of this child. We either get a yes or no answer. If this doesn't materialize, then we let her know this, that we need to try to explore some other source over the state, then she handles it from there.

[7]

Q How do you go about securing persons to operate foster homes in Stephens County?

A This is an open decision—always we are open for people to file an application for foster care. We may have speaking engagements there at the Civic Club, programs on the radio or spot announcements, advertisements in the newspapers. We have been known, say, to run a campaign, but we're always open for people who may want to apply to become foster parents.

Q You said that there were speaking engagements and this type of thing, do you personally do that sort of thing?

A Yes. We involve either myself and maybe, you know, some of the caseworkers in the services department also.

Q Do you know how many foster children you have in the county now for instance?

A No, that's handled by the specific caseworker assigned to that responsibility.

Q I believe you stated that you went to the district and then went to the state. Do you have any connection as to what occurs at the state level?

A Not really, it's—you know, we make the request and the Social Services Director may tell us to get the material together and mail it directly to a person in the state. We are responsible for getting the summaries together and information on the child, that is our responsibility.

[8]

Q Okay. Let's talk specifically about the matter at hand, that being Jimmy. Can you tell us when you first became acquainted with Jimmy?

A Jimmy was brought to my department by a relative—

Q Before you do that—are you going to refer to those notes? If you want to look at them, feel free.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

Q Do you recall when you first became acquainted with Jimmy's case?

A Yes. Jimmy was brought to our department by one of his relatives and a close neighbor of the family when he was three months old. Upon observations from, you know, lay people, because there was more than me involved, he seemed to be malnourished and not fully developed for three months as a child should be. This seemed to be an emergency as the child seemed listless, his head was larger than his body, his stomach protruded, his hands and his legs were just—no flesh, just very small. So, we carried the child to the Juvenile Court Judge, who made an observation and gave us an emergency order at the time to place him in foster care and get medical examinations. The parents were notified and he set a date for a Hearing, but the child was placed in an emergency situation at that particular time and he [9] was carried to a pediatrician, who gave a written report to the Court, the Judge, for the specific Hearing when the parents were involved. The Judge gave us the order for temporary custody; at the time he was about three and a half months old. He was placed in a foster home in Stephens County. The home was an approved home for us for infants, it was a widow lady. James was hard to discipline, he was a head-banger and he didn't seem to be fully developed, as far as developmental charts. And, this lady, as I said, was only approved for infants, so when he reached two years

old we thought he might have more stimulation in another home and develop. So we moved him into another home about the time he was two years old or just past two years old. He received good medical care during the time and it seemed as far as his physical development, to be fine. He did have the problem of head-banging, destructiveness, as far as his crib, and I believe he tore up a playpen by shaking. It was discovered that he had a hernia and after his placement in the second foster home he did have an operation in a local—in Stephens County Hospital for the hernia operation. This lady didn't feel that he was up to a two year old range and she felt that she couldn't cope with him and his problems of apparent temper tantrums and frustrations. So, it became necessary to remove him in an emergency to another lady there in that county, until we [10] could make some plans for him. So within that same year we had three placements to foster homes, in the hospital, before he went into a home in Fannin County.

Q What year was this, do you recall?

A This is where most of his behavior problems became apparent, he was referred to Crippled Children's—this was in 1964 and '65.

Q Where did he go next?

A Then he was referred to Aidmore Hospital for an evaluation, phychological, EEG, in an effort to determine what was causing the behavior problems, if it was physical and neurogical. He stayed there about two weeks and then I moved him from there to a home in Barrow County. During the time that I did move him—when I went to Aidmore to pick him up, I was unable to relate to the child. One of the attendants had to put him in the car. He

spit and threw things, and I had carried toys and stuffed animals, of course, to entertain him. He even threw those at me in the car. He seemed very frightened and he held on to the window handle until he relaxed and went to sleep. Then when we got to the foster home, he did the same thing. You know, outside he picked up a rock and, of course, being uncontrolled as far as aiming it, he hit the car with the rock, he spit at me. And, it was finally decided that the foster mother might be able to get him more accustomed to being at their [11] house if I left. So, we left him with these people.

Q What were these people's names?

A Timms. This was in November of 1965, he was placed with them. They worked real hard with him. We have records to indicate that they tried real hard to work with him and seemed to show some degrees of improvement, except at times when his attention span and low tolerance level would be evident. Then they had to ask for him to be removed due to circumstances. He never did quite relate to this particular family, he didn't stay there quite two years. Then in July, we found a home and went to the Satterfields, and this is in White County.

Q What year was this, please?

A In 7/18/67.

Q In July of '67, he went to the Satterfields?

A Right. And, this is where he had his longest stay.

Q How long was he there?

A He was there until 6/24 of 1970.

Q What responsibilities do your foster parents have with respect to the child's physical and mental well-being?

A Well, just as any parent would be to their own natural child. They are supposed to have proper physical examination, dental examinations. If there is a problem emotionally, referral to the proper source for evaluation and [12] treatment, if necessary. Our agency requires in the smaller children, with infants, monthly examinations and as they get older, you know, six months examinations or yearly examinations, physically.

Q I am handing you this file, which I have previously identified as the file containing the psychological information on the child. Do you recall when the child was first referred for psychological—let me rephrase that, when the child was first sent for a psychological evaluation?

A This file indicates that the earliest psychological was done in 1965.

Q Can you recall what—between 1965 and 1970—what psychological treatment or evaluation that the child was given?

A This would be under Crippled Children Services and this was the work with the nurse in Fannin County, with the referral to Aidmore pediatric psychological examination, and this is the reports.

Q So the trip to Aidmore was the first psychological evaluation?

A That we actually can recall.

Q Now, would you continue and I'm only concerned with the period, say, between 1965 and 1970. What other psychological evaluations did he have?

A Now, this is Doctor Clark at Aidmore in October of [13] '65, and the EEG was at Emory University Clinic in

October of '65. This record is a little bit fuller, because it gives some of the nurses' reports.

Q Is this still from Aidmore?

A Yes. It's Crippled Childrens Report, which would include Aidmore and it's more than this first one here, more detail.

Q If you're going to refer to the documents, why don't you—in the future, you don't have to do it with that one, but just identify them by date, if you could, and the letterhead, if there is one?

A I think the transmission of the material—December 12, '66, this is a psychological evaluation.

Q Who was that done by?

A This doesn't have any name, but when we submit a social summary for adoption we leave off names and this looks like a Doctor Young.

Q Who is Doctor Young?

A Florene Young at the Psychological Clinic at the University of Georgia in Athens. She felt he was a little bit—I can seem to remember—that she felt he was a little bit farther advanced and she wanted to test him again. So, she did so on April the 21st, of '67.

Q Another psychological evaluation?

A By Doctor Young. And, another one on May 1, '68.

[14]

Q By the same person?

A Yes, by Doctor Young. Then in '68, this is when he started exhibiting problems in the Satterfield home, because this changes—the psychologist and the referral—we have a psychiatric evaluation from Doctor Griffin.

Q Who is Doctor Griffin?

A He is a psychiatrist in Gainesville.

Q And, the child was referred to him when?

A October of '68. He was in the Satterfield home at that time.

Q He was referred to Doctor Griffin?

A Right. He also was seen by Doctor Goldstein on the same day.

Q Who is Doctor Goldstein?

A He's a clinical psychologist.

Q What resulted from these evaluations, anything?

A This indicated that he might need treatment and we set up ten treatments by psychiatrists.

Q Explain how that occurred, if you would, you say you set up ten treatments by psychiatrists?

A Well, the funding process and the money available for those, we have to get it approved and there is a special form for a request for psychiatric services that needs to be prepared.

Q Is that document you are referring to the referral [15] document?

A Yes, referral for psychiatric services. And, this was referred to the district office at that time, who gave the approval. That was the current policy in effect at that time, this was still in '69.

Q What happened after that?

A Then the Mental Health Clinic had something to do with it, this is a letter by Jean Meeks, who reviewed

Doctor Griffin's and Doctor Goldstein's evaluation, because he was having some problems.

Q Was this leading up to the approval for the ten treatments?

A No, that's after that.

Q Did the child receive the treatments?

A Yes.

Q Is that reflected in those files?

A I'm sure. Hall County Mental Health Clinic was to provide those. That's the letter indicating where they were set up. Those ten treatments were given through the Hall County Service—Mental Health. Then there was a mental health clinic that was set up as a satellite in Toccoa and we started taking him to the Toccoa Mental Health Clinic.

Q Who was in charge of that health clinic?

A This was a Mr. McFarland.

[16]

Q How often was he treated there, do you know?

A It seems that he started in May of 1969, and continued until he was placed in Central State Hospital, so it would be a whole year.

Q As I understand, he received treatment in Gainesville—

A Prior to May of '69, right.

Q —and then received treatment in this—

A On an outpatient basis.

Q —period at the mental health clinic?

A Right. This next document that follows in this file is the running narrative by Mr. McFarland, ACSW. And, it also has notes—but he was also seen by Doctor Cole and Doctor Curtis.

Q Who is Doctor Cole?

A Doctor Cole is the Ph.D. and Doctor Curtis is the psychiatric consultant, they both were connected with the mental health clinic in Toccoa at that time; that's from their records. The next February 2nd, 1970, is a letter from Mr. McFarland to Nell Crisp, with a copy to Stephens County Department—Nell Crisp was the caseworker who supervised Jimmy in the Satterfield foster home. She was not connected with Stephens County, it was White County and she was the worker that supervised him. The next document has medical attachments with some psychologicals prepared [17] by our worker, Barbara Carpenter, which supplements the social study update for adoptive placement. And, this next is a copy of the last contact with Doctor Cole and Doctor Curtis.

Q When is that dated?

A June the 1st, 1970.

Q Do you know when the child was sent to Central State Hospital?

A In June, 1970.

Q Now, do you recall or is there any—are there any documents in that file pertaining to why the child was sent to Central State Hospital?

A In this particular file here, Mrs. Carpenter was our caseworker and she worked with the mental health clinic there in Toccoa. And, there is a copy of a letter that she

had sent to Mrs. Pittard here in the district, who was our Field Rep. at that time, stating that Mr. McFarland had indicated that there was not any—they had recommended institutional care and he did not know of any institution for Jimmy, other than Central State Hospital; this is from a letter from Mrs. Carpenter to Mrs. Pittard.

Q Do you have any records of any conversations concerning the same subject to that file?

A This is the one that substantiates it here, it's a recording of—caseworkers at that time made recordings [18] of contacts that they had.

Q And, what does that reflect—he was still in the Satterfield's home; is that right?

A Right; it was still hearsay. And, all of this time he was having trips to the mental health clinic provided either by our worker or a volunteer worker, or the worker in that part. This indicates that at one time, through Mrs. Pittard, that she had—since institutional care was recommended that we try the Village of St. Joseph or the Ethyl Harp Home.

Q I'll get to that in a moment. What I'm concerned about now is, is there anything in that record that indicates who recommended that the child be sent to Central State Hospital?

A This is in the form of the letter that came from Mr. McFarland at the mental health clinic, and the contacts with him and the Public Health Nurse about an application to Central State Hospital.

Q I'd like for you to be more specific. What does that page reflect concerning this?

A This contact on 6/1/70, worker talked with Mr.

McFarland at the mental health clinic, but he could offer no services for James. He did state that it would probably be better for James if he could stay with the Satterfields. Mr. McFarland says he knows it would be hard for anyone to [19] live with James since he is starting to express his anger and hostility outward, and this will probably increase as he gets older. He stated that probably an institution might be good for him as no one would be trying to establish a one to one relationship with him as they would in a home situation.

Q That's the Director of your mental health center there?

A At that time, yes.

Q And, was it at this time that you had him sent to Central State Hospital?

A Yes.

Q Now, let's consider the other steps that you all—is Jimmy on the—have you taken any steps to have Jimmy adopted, do you recall? How does that work?

A Permanent custody was given to our department in 1966, and actually when we have permanent custody of a child when we've been—you know the Court Order says for the purpose of placement for adoption. We then prepare what we call a social study on the child, you know, summary of life experiences, current health, emotional and social adjustments, paternal background. And, because Jimmy had had so many moves and problems, we made an urgent request to the state office to try to find a home for him for adoption, prior to him going to the Satterfields. So, once [20] a study is submitted it is supposed to be available for consideration at any time. This is on the state level.

Q So, the adoption procedure is on a state level and the county has nothing to do with it?

A That's right. The county's part is submitting the social study.

Q Now, before Jimmy being sent to Central State Hospital, were there any other institutional alternatives considered?

A Yes, we did explore—we wrote letters to the Ethyl Harp Home and the Village of St. Joseph. Those two institutions at that time, to our knowledge, would take children with problems such as Jimmys or an I.Q. level such as Jimmys. And, this record that I was just referring to also points out that Mrs. Luce, who was the admission counsel at the Ethyl Harp Home, happen to be in our office on another matter and she looked at Jimmy's records and said it's not likely that they could meet their program.

Q That was at the Ethyl Harp's Home?

A Right. That recording is in response to the letter we wrote to them.

Q And, that response is in this file, which is marked psychological?

A Right. Recording by the caseworker.

Q What about at the other institution you mentioned, [21] St. Joseph's?

A The Village of St. Joseph requires that there be a foster home situation for them to have their visits, you know, to return to on holidays or week-ends. And, we did keep the Satterfields in mind, because they were very fond of Jimmy and we wandered if this could be a resource

for him to, you know, have to go back to for visits. And, they said they could not take on this responsibility.

Q So, you had no foster home?

A No foster home and the institution plan fell through.

Q Okay. So, he was sent to Central State?

A Right, but we were in consultation with the people in mental health on this and this was the advice given. And, we talked to Doctor Charles Bush in Atlanta by telephone and told him the situation and then he called back and told us that Jimmy could go on the 25th. So, this was all in June of 1970.

Q Did you have any recommendations from any other person, other than this—is it Doctor McFarland or Mr. McFarland?

A Mr. McFarland.

Q Mr. McFarland. Were there any recommendations other than from his center that the child be institutionalized?

A I'm not familiar with that, unless I searched back [22] through the records.

Q Was that the primary you sought institutionalization?

A The children's unit at that time had just been established, the building at Central State, and this was the type of recommendation that—they were saying that they could treat children such as Jimmy. At this time they had to have an I.Q. of over seventy and they could deal with problems such as he had. Now, those regulations are changed now, but this was true in 1970, when Jimmy was there in '70.

Q Now, considering the periods since 1970, did you all make any efforts after 1970 to do anything with Jimmy?

A Yes,—may I add something?

Q Sure.

A When Jimmy was taken to Central State and went through the admission procedure, they did some more testing to see if he was eligible to be admitted. I'm sure after he got there, if they found out that he was ineligible, they would not have taken him that day, but they did go through this.

Q Let me phrase the question like this: When a child from your county is taken out of a foster home and put into an institution, what happens at the county level then concerning any future placement of him?

A Well, always the purpose of the county department when we have custody of a child is try to move him on into [23] something that is permanent. If it's temporary custody, work with his parents to get him back with his parents. If that doesn't materialize permanent custody that leads us to permanent placement.

Q So, you all are solely responsible for the child?

A Right.

Q Is an active file maintained on the child?

A Right. There is never a time our department should have a child hanging in limbo. I mean the purpose is to work toward permanency.

Q Is he assigned to a caseworker?

A Right.

Q Now, after 1970, can you tell us briefly what attempts were made on Jimmy's behalf to get him out of the hospital or to place him somewhere else?

A Basically, we kept the Satterfields still in mind for Jimmy, because they were real fond of him and I think it was really heartbreaking for them to let him go. They did have him back on visits. Each time there was a visit, holiday time, when he first was admitted, he did return to the Satterfields for visits in their home. The record indicates that in '71 was the last time he had a visit. So we checked back in the record and found out that he had been a disturbing factor during that visit and she had other foster children in the home. So she discontinued having him [24] back for visits, because he didn't seem to relate well with the other foster children.

Q Mrs. Satterfield had other foster children?

A Yes, after '71.

Q Do you recall how many she had?

A That was not a home in Stephens County, but from the record, I seem to recall that there were two girls there.

Q In addition to Jimmy?

A Right.

Q So, Mrs. Satterfield—this wasn't her only experience with a foster child?

A That's right. I believe at that particular time the last time he was there, he got upset and tore the screen door off and broke up some canned vegetables, and tore his own shirt off.

Q What other attempts were made to secure a placement that you recall?

A Now, I was checking the dates—we had a request in Toccoa, Stephens County, by some people who wanted to be boarding parents. So, during Christmas of 1971, we brought Jimmy to spend the Christmas holidays with them. And, this is unusual, I know, but after Jimmy visited with them, they withdrew their application to become boarding parents. Then we did try to find something else for Jimmy [25] and we always went back to the Satterfields, you know, to see if they would take him and we got a negative reply until 1974, but also during that time we had another couple in Stephens County that was interested in becoming boarding parents. Jimmy did not visit with them, but we did ask them if they would take him for one of his holiday visits, they said, no, that they would not be able to take him. So the next visit was back with the Satterfields in '74, this was summer of '74. And, continuing effort to follow any lead had always been in the back of our minds, because I did some speaking at Civic Clubs and carried some pictures of Jimmy at one time to a Civic Club meeting to see if we could solicit some interest for him as a particular child. He was referred to Child Service and Family Counseling through Mrs. Dixon in Atlanta, you know, for possible placement.

Q Well, I'll get back to that in a moment, I want you to go into some detail. Are the Satterfields not in Stephens County?

A No, they are in White County.

Q How was that placement arranged originally, do you recall?

A Through the district.

Q Through the district?

A Like we explained, you know, if we didn't have a

[26] place in our county, district, we would consult a Field Rep.

Q So, there has been some coordination through the district for Jimmy?

A Right.

Q Now, what efforts, when you were relating how you did this procedure, you said you went from the county to the district to the state; were any efforts made by the county to get him into the state placement system?

A Right. The one that I recall most was in '73, to Mrs. Dixon from Child Service and Family Counsel. Also during '73, we sent materials to Muscogee County for foster home recruitment for special children. This was an effort on their part to try to see what they could do to meet the needs of special children.

Q Muscogee County?

Q Yes.

Q Do you know any more about that program than what you just described?

A I just know that it was approved—the District Office, we learned that they were starting a recruitment campaign. It probably came through the state, that they would take any child with special needs through the state and do the publicity. We sent some pictures in that area of the state, because he was not known, with a short summary about him. This was sent to Muscogee County to be included, [27] but we had no feedback from that.

Q By no feedback, I take it you mean no offers to take him?

A Right.

Q Now, you also mentioned at the same time something about a state list; would you explain that?

A Yes. I understand that children that are hard to place or children with special needs, a small summary is prepared and circulated throughout the state through the Field Reps., it comes from the state office.

Q Did you refer Jimmy to the state for that purpose?

A Yes.

Q Is that reflected in your records?

A I don't believe it's in any of these records, but for a telephone conversation I had, I knew he was still considered on that list as of November of '74.

Q Now, is it your belief that Jimmy is still on that list—what is the state list, can you explain that?

A It's just a memo type thing that has children referred to by first name and their birthdate and maybe which county has custody, and just a brief description.

Q And, Jimmy's been on that list since when in 1973?

A As far as I can—feel like it's 1973. I thought I might have quoted that in this material right here, but I [28] don't see that I did.

Q Now, were there any other instances where during this period there were inquiries made to other institutions besides Central State?

A No, other than the Village of St. Joseph and Ethyl Harp's that I've already talked about. We did a special adoptive search that I haven't mentioned. The Casper home in Hall County and the Helton—individual parents.

Q Go ahead and explain that.

A This was through our district helping referring us to possibilities. One was the Casper home in Hall County, this would be adoption, and this was in a letter of June in 1972. And, then Helton was an individual single parent adoption and this was a White County man. Then there was also an inquiry into Franklin County, which would either be adoption or foster boarding care leading into adoption.

Q Do you know what happened to the possible placement with the Caspers?

A The letter in the folder from Barbara Griffin indicates that they were having some financial reversals at the time and would not be considered for Jimmy or for any child.

Q What happened to the single parent placement?

A This man lived next door to his family and would [29] rely on his family providing care for a child that he would adopt and his father died of cancer, so he withdrew, but anyway altogether.

Q So do you know of any other placements that have been attempted on behalf of Jimmy during this period?

A That's about all I recall, until it gets to this caseworker who is involved with him now. We didn't make any reference to those state referrals where we had one piece of evidence from District Three that they didn't have a home for James.

Q Would you explain what that is?

A That was one of the referrals statewide from the Field Rep. similar to this issued. Mitch Turner, you know, replied on a memo that he didn't have a home for a child such as this.

Q That's where your district refers to somebody else?

A Right.

Q So, there were responses from other counties I take it?

A Right.

Q Are you familiar with the Alpine Center?

A We know of the Alpine Center, it's not a residential center.

Q Did you investigate that as a possible—

A Yes, we found out it was not residential, it had [30] been suggested. It's to treat emotional problems, but it's not a school level and it's associated here in Gainesville, I think, in conjunction with Brenau College, but not residential.

Q Is that the third institution that you—

A Right. We grasped at most anything we heard about.

Q Now, I may have asked you, I'm not sure—do you ever stop recruiting for foster homes?

A No.

Q And, do you know if you have any children awaiting a foster home now besides Jimmy?

A We do not have any.

Q And, he is assigned a caseworker?

A Right.

Q Do you know if he has always been assigned a caseworker?

A Yes, this is a policy in our department to consider the case load. There is a card on each active child, it becomes the case load for the caseworker, assuming the child with their responsibilities.

Q So, on every active child there is a file and there is some sort of index card also?

A Statistical card, right.

Q Are there any reports that are filed by the department which reflect the existence or non-existence [31] of this child?

A Right, with a monthly report.

Q It's a file reflecting—

A Each child that we're responsible for and the activity of that particular child.

Q And, Jimmy is carried on each of these monthly reports?

A Right.

Q Are you responsible for those reports?

A The caseworker and a clerical worker.

Q I mean do they come to you or through you?

A Well, I see them once, but they are supposed to be accurate and prepared when they get to my desk.

Q Now, the third file that we haven't mentioned anything about concerns reports on Jimmy's behavior. How are these reports—and particular those that are filed in that file I just gave you—how are those reports prepared or by whom are they prepared?

A I need to go back, because procedures have changed, the current—is different. Back when Jimmy came into

care, the home county and the worker responsible for the case would prepare a narrative, social summary data, information that we may have obtained from neighbors or foster mothers. If the child was in another county in a foster home, Stephens County would not go into another [32] county, you know, to visit with this child. He became the responsibility for supervision for the worker assigned to supervise that particular foster home. The responsibility was that they would keep a case record and narrative pertaining to each visit, office contact, telephone call that pertained to this particular child and they were to share these records with the county of responsibility.

Q And, that's how those records are prepared?

A That's right, that was the procedure, back when Jimmy came into care.

Q How long was that the procedure, do you recall?

A Well, it was there when I came and I think it just has changed with this CSIS data control.

Q A recent change, when did this form—

A I think it must have been '74 or '73.

Q Based on your position as the County Director and your experience since 1963 with this child, do you have any opinion as to why you haven't been able to get him into a foster home?

A Well, mostly the records here indicate that he was given up, because of the behavior patterns and foster parents have been unable to cope with him. This is reflected throughout each placement that he has had.

Q Have the same problems been reflected in every home?

[33]

A It seems that even with visits, you know, he has exhibited some kind of behavior that has not been acceptable to foster parents. Now, I really have not talked to a lot of them just to say why can't you have him, you know, this way. They just have the right to choose to accept or reject a child we ask them to care for.

Q Have you observed any improvement, based on those reports, say in his recent visits?

A From the record it indicates that one of his visits that he had in '74,—he loves watches, this is a favorite thing of his and he got a little upset, he couldn't watch a special television program and went into a room and tore this watch up, and an electrical receptacle on the wall, he pulled apart.

Q And, he's still demonstrating these behavior traits?

A On one of the visits back to the Satterfields, he seemed concerned about a pair of shoes he had on and he reacted to this, about the shoes,—to destroy—

Q Are you all still attempting to place Jimmy in a foster home?

A Yes.

Q Have you made any attempts to place him in a home with persons with any particular qualifications?

A Actually, I don't think we've had any requests, other than the one that we had in '74. One of their references [34] when we got their application and we contacted references, they had had some experience with emotional children.

Q Who were those persons?

A Mr. and Mrs. Pritchard. And, this might be referred to Mrs. Schoonmaker later.

Q She was the social worker at that time?

A Right, she was the one handling it.

MR. LACKEY: I'm through.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

EXAMINATION BY MS. LINDBLOOM:

Q Mrs. Whitaker, I would like to just clarify a few things when you were speaking about how you as a director of the local county defacs (DFCS) office would go about obtaining foster home placement for a child that was your responsibility. You mentioned—and what I would like to do is summarize what I think you were saying, if I'm correct, please tell me; if I'm not, you can just react to what I have to say. For foster home placement as opposed to adoption, the local county defacs (DFCS) office looks within their county as a first step; is that correct?

A Right. A foster home has to be an approved home. It means it has to have gone through an application process, studied, and met requirements, and already approved before [35] we place a child in it. Some of the homes are already in existence when we have a child to place in foster care.

Q And, the local county defacs (DFCS) office would go out and check out the home and would approve it or not, but would also be doing the recruitment of actual foster parents?

A Right. So it can be an on-going process. You can have an approved home and you can have homes in application status, you can have homes in study status. We use homes that are already in approved status.

Q But basically, most of the foster homes that you actually have that are developed within your county or developed by the local office or is it—

A By the local office.

Q You made reference to referring a case if you're unsuccessful at the county level to the state?

A No, to the district first.

Q What responsibilities does the district office have, what is your understanding of what they would do?

A Well, since the Field Rep. or—or Social Services Director—we might give them three titles, you know, keeps a master list. She delegates this to her secretary, because she is mostly here all the time and we would say, you know, we have so and so to place, age so and so, we don't have any homes in our county for this child, [36] would you give us a list of some vacancies, because most of the homes that are already approved, they know the age range that they can take. In other words, we wouldn't take a teenager and try and place him in a home, an approved home for infants. So, then she doesn't get into the aspects of behavior or social background of the child, she just gives us a list of vacancies. Then we would make the direct contact with the worker who supervises that home in the district level.

Q Okay. It's your expectation would be that once you made a referral to the district office, that you would be getting the names or possible sources back and you yourself would be making the contact?

A Right. And, the name of the worker who supervises the home would be given to us, too.

Q Okay, fine. What about further than that, beyond the district office, if you're still hunting?

A If we don't find a place for this child there within our district from one of the resources that she has given to us, we get back with the Field Rep. in some manner, you know, to tell her this didn't work out we need a place. And, then, she through—at that time the process would be that she would contact people in similar positions over the state to ask if—then give them some background information on the child, if they had a home to take care of [37] a child such as this. This would be across district lines.

Q You mentioned before to state offices. Now, is that the next step in this process?

A Right. Now, I believe since I said this—when this case came up and what current regulations are, are a little bit different. And, I think when Mrs. Taylor comes in she might give you what's current, but what I'm speaking about is what we might have done then, because I think now it is on a state level with the circulation list as I said, you know, circulating throughout other districts. You know the little summary and sent to Mrs. Dixon's office, but anyway it gets circulated one way or another. I think at the time we were working with Jimmy it was through the district level and like I might feel like—I might see another Field Rep. and say, you know, I have need of this, either by telephone—and she tried to stay as close to us so the transportation would not be a big problem. It's unusual to have a child in South Georgia, you know, boarded from North Georgia, etc.

Q At this point is it the person in the district office level that's initiating these contacts? In other words, you mentioned like Mrs. Dixon as a contact, would the district office person make that contact or would you again at the local defacs (DFCS) office do that?

A We would get the material together and it would be [38] according to whatever our Field Rep. told us to do. If she said mail it directly to Mrs. Dixon, with a copy to her, we would do this.

Q So the local defacs (DFCS) office then would strictly go by the recommendations of the district office?

A What they advised us to do. Now, in this particular file here on Jimmy is a letter that went directly to Mrs. Dixon, addressed to her.

Q From yourself?

A Right. Well, from our county office, the worker who was handling it at the time. And, that was for, you know, referral to Child Services and Family Counsel.

Q What was your expectation in writing the letter to Mrs. Dixon as to what her responsibilities or what her action would then be after a referral from you?

A Then we would expect that she handled it from writing or getting it to the proper source. And, we do have a letter, I think it's addressed to Mrs. Mildred Clark in Child Services and Family Counseling, enclosing this material.

Q Okay. So you said that you would expect that she would handle it from there?

Q Right.

Q In other words, that she would then—

A Make the contacts necessary.

Q Is this above and beyond, let's say, even the efforts [39] that the district office would make?

A Right. On up to another level.

Q Did you ever receive any response from Mrs. Dixon back, you know, to your letter?

A Not to our county, no.

Q Again, that would be just your assumption that once you made the contact with her—

A Could I speak from some previous experience from referrals that went like from our state office to Child Service and Family Counseling, that did bring some results, Child Service and Family Counseling then did get back in touch with us on their own, that did bring some results from a request. They made a call to us and said, you know, we understand you have this child. Now, I'm not speaking of Jimmy, I'm talking about something that did bring results.

Q Right, that's fine, I'm trying to understand now how the system operates. So, basically, from what you've said, you would continue—local defacs (DFCS) office would continue efforts for foster homes, that would be on a continuing basis?

A Right.

Q And, then if you were unsuccessful you then contacted the district office and if further help was needed you would make the contact to Mrs. Dixon?

A Right.

[40]

Q Again, to clarify that adoptions—okay, you were separating these that they are done differently, so the pro-

cedure is different for adoption. Now, as the local defacs (DFCS) office, could we just get that clarified what your first step is?

A We have to have permanent custody of the child, with the right to place it for adoption. We prepare the social summary, social data, background information and submit it to the district office, because we cannot search for a home for a particular child.

Q Is the primary responsibility then for recruitment in terms of adoption, we're speaking now of adoption, is that in the district office or is that in the local defacs (DFCS) office?

A It's mostly outside of the county level; it could be district or it could be state.

Q Okay. And, your understanding of the responsibility of a local defacs (DFCS) office would be to prepare, you mentioned, like the social summary and refer that in turn to the district office?

A Right. They would not have any idea that this child was available for adoption, unless they got the material from us. And, it has to have the verification of the child's birth, the court order attached that we do have the right to seek a home for him with the right place for [41] adoption; his background information summary of life experiences, social information, emotional problems, all the medical attached to it, any reports on psychological—

Q But, basically, recruitment then, in terms of any efforts that were made and in terms of an adoption, you know, on this basis, would be at the district office level as opposed to your own defacs (DFCS), local defacs (DFCS) level?

A Right.

Q Who makes the decision as to what type of placement to seek for a child—again, make the assumption the child is in your custody, who makes the decision? We've talked here about adoption, we've talked about foster home placement, who makes that decision?

A We have to either have a custody order from the Judge or a voluntary request from the parents to place the child.

Q Okay. In the case of Jimmy—maybe it would be helpful to come down to specifics—how was it decided as to the type of placement to seek for Jimmy?

A At the time he was brought into foster care, on the local level, he was an infant, we had a home that was approved to take care of infants in his age, you know,—

Q A foster home?

A —already set up. Now, infant homes—I need [42] to clarify that approved for infants, is from zero to two.

Q When we were talking generally before about the procedure for adoptions, when we were just speaking previously, you mentioned that this was basically that once you made your report, this is basically the district office responsibility, that they would do the actual recruitment for adoptive homes; is that correct?

A I don't think you would use the word recruitment, because people are applying for adoption all the time and we're doing studies, you know, for adoption and approval. They may seek through what is already approved to see if there is an appropriate home for the social study they have received on a child. Now, our understanding, for Child Service and Family Counseling, they have the

social study first and seeks a home for the child that is ready to be placed.

Q In other words, would the district office notify you of what efforts that they were making in terms of adoption?

A If it was it could be on just verbal conference type—you know, through contacts at conferences. This is where a lot of these are discussed, our problems and our efforts and our needs. We have conferences with our district level and particular where it becomes their problem area.

[43]

Q Specifically, in Jimmy's case, was a decision made to either choose to make efforts like for foster home placement or for adoption or for both?

A After he was in permanent custody it was both, either one that we had. We preferred adoption after he was available for adoption, because that request that went out before he went to the Satterfield home was saying please, urgent, you know, we need to get him into a permanent situation, rather than so many moves.

Q Okay. Then both were pursued, but adoption was preferred?

A Preferably, yes. You need to move a child into permanency.

Q Certainly. Are you aware of—to the best of your understanding or your knowledge, is the adoption search still being conducted right now and has it been?

A I don't have anything to substantiate in this record, but in our records that it was; but I understand there is a letter somewhere that Mrs. Poss and Mrs. Dixon were

agreeing to Child Service and Family Counsel, whichever home would be appropiate, if they could find either foster or adoption. This is in July, '73.

Q But to your knowledge, do you have any idea what has happened in terms of the adoption?

A Not now, no.

[44]

Q You mentioned in terms of your familiarity with J.R's case that you were a caseworker at the Stephens County defacs (DFCS) before you became director; is that correct?

A Right.

Q So you were familiar then with Jimmy's case prior to the time of his admission then to Central State in June, '70?

A Basically, until '68, would be my primary responsibility. From 1962 to 1968, I was the caseworker with Jimmy.

Q Could you explain a little bit more as to who actually made the decision that James was going to be institutionalized or the decision making process that resulted in that?

A I'm not sure that I would know the answer.

Q Could you be a little bit more specific?

A I think that I personally would have the knowledge of, you know, how that decision was made. I have just quoted from the records that the caseworker had contact with Mr. McFarland and he said, you know, that he would recommend institution. I did not have direct knowledge at that time.

Q You did or did not then have personal knowledge or involvement in that decision?

A Not directly, because the caseworker handles it and I'm sure that it was in consultation with our Social Services Director and the caseworker, and probably I was in [45] on it, but I can't recall, you know, the direct account of it.

Q Is there a procedure—in other words, is there or do you have any directives in any of your manuals or any guidelines that you have as to how a decision is supposed to be made by a local defacs (DFCS) office, such as admitting a child to an institution, assuming the child is in defacs (DFCS) custody?

A Well, other than what I had said and consultation with the Social Services Director.

Q It's your understanding that the Social Services Director would discuss this?

A Yes. And, we say this is the recommendation, you know, by our contacts.

Q Basically, then, the records you were quoting from was referring to the caseworker at the time; in other words, the records and things you were referring to—

A Right, were from the records, right.

Q You explained before now that James was in White County, the Satterfields were in White County, that he was in a foster home in White County, but he did maintain a Stephens County caseworker; is that correct?

A Right; her responsibility.

Q What was her name at that time who was the caseworker that we are speaking about?

A Let's see, probably—probably, two caseworkers [46] at that time, Mrs. Theo Bracewell, because I read in the record where she had provided some transportation for him at the beginning sessions of mental health and then she left and Mrs. Carpenter was the caseworker assigned to Jimmy. It was Mrs. Carpenter's records and recordings that I was referring to earlier.

Q So, basically, talking about Mrs. Carpenter's personal involvement, to the best of your knowledge, did she personally visit James, did she talk with him and visited into the Satterfield home?

A It's not the usual policy for our worker to go into another home to supervise, but she did have contact with him by providing some of the transportation to the mental health clinic. We either can do that or pay the foster mother to provide it, because he is our financial responsibility.

Q Okay. Let me just understand this. She did not have any personal—in other words, she did not go into the Satterfield home?

A Not as supervision, this was done by Mrs. Crisp and I think he had a couple other workers in White County at the same time.

Q You mentioned before that it was Mrs. Carpenter's records that you were referring to in terms of the times of admission?

[47]

A Right.

Q To your knowledge, did Mrs. Carpenter have any kind of training or any clinical or psychiatric training?

A No, I'm sure she was going on the recommendations of the mental health clinic, because if he was referred this is the people she would be using.

Q Is there anything in the record that indicates like any procedures that she might have gone through, in terms of getting—authorizing such a step? In other words, you mentioned the record that she did keep and the notations of telephone calls, was there any form that she had to fill out in terms of getting anyone's authorization, for instance your authorization to make the move that she did?

A No. I think the calls visit meant that she had voluntary placement agreement and we don't have a copy of that in our files, and I'm not sure if one was carried. I really do not know. I do know that from the record she called Doctor Bush, you know, in Atlanta, Doctor Charles Bush, and he made a call to Central State and said he could be brought on such and such a date.

Q Okay. I know this is a series of sheets, but can we move to the one where it starts up at the top telephone calls, move down, the next item down would be field trip, dated 6/24/70; do you see the page I'm referring to, up at the top?

[48]

A (Indicated yes.)

Q Could you read at the top where it says telephone call, could you read what that says there?

A Worker talked with Doctor Charles Bush?

Q Right. Yes, please.

A With the State Health Department about emergency admission of James for Central State Hospital. He

said he would check on this and call me back. In a few minutes Doctor Bush called and said he had talked with CSH and that we could bring James on either Wednesday or Thursday, June 24th or June 25th, between nine a. m. and four p. m. Doctor Bush said that since we have permanent custody of James, all we need to do is complete the voluntary admission form and carry it back with us. No Court Order is needed.

Q Okay, fine. To your knowledge, other than this was Doctor Bush ever sent a complete record or background on James? In other words, what I'm asking is, was there ever any personal involvement of Doctor Bush with James' case?

A That I do not know. If he's with mental health, he could have had access to the mental health records.

Q I would like to also refer you to something else we spoke of before and this is when you went through on the psychiatric evaluation, that folder, and you mentioned the cumulative running reports of the Stephens County Mental [49] Health Clinic in Toccoa had kept on James beginning in May of '69, continuing through on to his admission. You mentioned that Mr. McFarland, a recommenation from him—and we're talking now about the reasons and the basis behind James admission—in that report do you see the notation that begins 5/26/70?

A (Indicated yes.)

Q Could you read that, please?

A This is by Doctor Curtiss, a psychiatric consultant with the mental health clinic in Stephens County. This young man is having an acting out problem. He basically acts out in an agressive fashion and is sometimes almost uncontrollable in his behavior. However, he seems to have

made considerable progress and strength since staying in the present foster home. The present foster mother seems to take a very firm, but loving approach with him, which I think is very desirable. The difficulty in school I think has been that the teacher, which he has now, is not able to deal with his acting out behavior as realistically now as the one he had previously. It is my recommendation that he be placed in a school where there is a relatively firm reasonable displinary policy, which is consistently applied. I would also feel that it would be a benefit to him if he could stay in the foster home for an additional year since he has been in seven different foster homes, and I feel that [50] this must be very upsetting to him. If he has to move it would be even more upsetting to him. I do not feel that medication is indicated that would be of much value since as much medicine as would be required to tranquilize him would essentially knock him out.

Q What was the date of that report again?

A This notation from the record is dated 5/26/70. And, as far as I can determine that's the only time Doctor Curtiss saw him.

Q Was it your understanding either from the records or if you have personal knowledge, do you have a record of either Doctor McFarland or Doctor Curtiss initiating, making some type of request to you to place James in Central State, do you have any record that this is what happened or was being issued from Mrs. Carpenter to them?

A I think what would be done is that she would be in contact with them in discussing this case and for their recommendations, because I—this would be an opinion—that our workers would not go to the idea of Central State, unless it was given to us from somebody else for

the particular person. And, I read from this letter where she wrote to Mrs. Pittard indicating that she had been in contact with Mr. McFarland on June 1, 1970, but he did not know of any institutions other than possibly Central State Hospital.

Q You mentioned in there that there was a letter, [51] February, 1970, of Mr. McFarland to you, do you have that there?

A Yes. It's to Mrs. Crisp.

Q In the record that you've gone over and you've been speaking about now before, is there any other indication of any other information that Mrs. Carpenter might have used to make this decision to have James admitted to Central State Hospital?

A I really don't think that it was Mrs. Carpenter's decision, I think that it was recommended to her to follow through with the recommendation.

Q Who was it recommended to her by, do you have any documentation of that?

A That's the letter I read to you where she had just mentioned that she had written to Mrs. Pittard that she had been in contact with Mr. McFarland and that he did not know of any institution, other than Central State Hospital for James.

Q Are you referring now back to receipt of Mrs. Carpenter's notations of June 1st, where she said again a notation for telephone call, that she talked with Mr. McFarland at the mental health clinic, but he could offer no services, he did state that it would probably better for James if he could stay with the Satterfields?

A I'm quoting from a letter, which she has under her

[52] signature that she had sent to the Field Rep. She said I talked with Mr. McFarland about any suggestions he might have for James, but he did not know of any institutions, other than possibly Central State Hospital.

Q Okay. Basically, we're talking about the same date, the notation on here is also June 1st, 1970; is that correct?

A Right. But this is what involved in decision making, because we said we needed to bring in the Field Rep. on a decision such as this and this was her notification of this decision.

Q Do you have any documentation from Mrs. Pittard back to Barbara Carpenter that she authorizes or recommends admission to Central State for James?

A I don't think the word authorize is what we would need. I think there is a letter from Mrs. Pittard somewhere making some suggestions, but it's not in this particular folder.

Q Was there any written authorization or approval from anyone, other than what we have here in terms of Mrs. Carpenter's efforts, prior to the time of admission, the efforts that she made in the notations here, is there any documentation of anyone within defacs (DFCS), either at the state level or going down, who either noting approval of the decision or authorizing such a decision?
[53]

A As I say, I don't think the word authorizing is what we have and what we do. It was recommended to us and she was following a recommendation by contacting Doctor Bush in Atlanta to see if this was a possibility. And, he gave his approval stating that the child could be admitted and gave her an admission date.

Q Mrs. Whitaker, you had mentioned when you were talking about—when Mr. Lackey was asking about the

behavior folder and you were going through and speaking about that—you mentioned an improvement that your records had indicated, your records had indicated some improvements, and you mentioned, I believe, a foster home visit in '74, where James had exhibited some type of agressive behavior, whatever, acting out; is that personal knowledge or is that just that you remember from reading the records?

A This would be personal knowledge of Mrs. Schoonmaker who is here. This would be from the record, which would be recent, but she would be the caseworker that would be directly involved in this particular instance.

Q Are you aware of the Central State Hospital recommendations and reports of James' behavior and improvements since he was hospitalized?

A Is this the recent material that we got in November that we requested?

Q Well, specifically, that, but also on a continuing [54] basis since James has been placed in there; are you aware of the Central State Hospital personnel, their reports and recommendations, in terms of James' improvement?

A I think the only thing we have that's in writing from them is the recent one that we got back in November that I requested to update his material. And, then the last one I think that's in the record is in '73 that they sent us.

Q Okay. You have a report from '73, and then the next information is—

A The one we have in '75, right.

Q In your efforts within your county, or in the county,

to recruit for foster homes, within your experience, do you find that some children may be easier to place than others?

A Over the years, yes.

Q Could you elaborate on that and give us the benefit of your—

A Occasionally, there are children who are placed that maybe do not react to specific foster parents or specific foster parents may not react to them that maybe might be something different in school or on the playground, agressive behavior, acting out, that would cause them to ask us to move a child, but those situations are rarer than successful ones.

Q Based on your experience in attempting to locate [55] and work with foster homes, can you make any statement, in other words, as to like the age, is it easier to place like a girl than a boy, a two year old child as opposed to a twelve year old child; in other words, do you find—

A Very definitely. The younger the child, the easier it is to find a place. And, preschool, very definitely, easy. For school age children it's hard to find homes for and teenagers, it's just almost nil.

Q Is there any other—I've mentioned age as a factor there, is there any other factor that might come into play there, in other words, that would make placement more difficult?

A Well, it's been a good number of years since I've really has the direct contact, you know, but foster parents do seem to be more selective now than they did in the past when I really handled it. This is from, you know, problems that's coming across the desk.

Q Well, a child, let's say, that has a physical handicap, would that child be easier to place, harder to place?

A I think it depends on the handicap. In all the years experience, I've never had a handicap child.

Q Let's assume that you were going to be working to place a particular child, let's assume that was what you were setting out to do, if that child was presently in an [56] institution, do you think that would have any affect on whether it would be easier or harder to place that child, having been institutionalized?

A What we do is that we tell the people that we are contacting about his background and what it is, then we give them the right to accept or reject.

Q Do you feel, based on your experience, that the foster parents that you've come in contact with that that would be a negative factor in terms of their interest?

A At times it has, because we have to be honest with them and tell them what the problems have been and what the good points are. They need to be aware of this.

Q Do you think that going to the weight, in other words, of the child's present institutionalization, would that have any affect like if the child was young and institutionalized, would it be a drawback?

A I think it would be dependent—that would be pure speculation on my part and it would not be a definite answer.

MR. TARUTIS: Off the record.

(The parties went off the record for a brief period of time.)

MS. LINDBLOOM: That's all.

RE-EXAMINATION BY MR. LACKEY:

Q Counsel for the Plaintiff had you read certain [57] portions of that summary. Specifically, she had you read a portion beginning the fourth paragraph down from the top, styled telephone call. Would you drop down one paragraph, is this the contact you were referring to concerning the Ethyl Harp's Home?

A Yes.

Q Where was the child during this period, where was he located?

A He was still in the Satterfield's home and they had requested his removal, and these were in our efforts to find a replacement for him.

Q In other words, on 6/17/70, the Satterfields requested that the child be removed from their home?

A It was earlier than that, wasn't it?

Q Well, I was just looking at the log and what it says there.

A This is—the 6/17/70 was their decision that they could not have him back to visit with them if we did send him to St. Joseph's or this was the—our efforts to find another place—I'm not sure when the Satterfields decided that they couldn't keep him, but it's in correspondence and this reflects, you know, the activity that Mrs. Carpenter did in trying to find a replacement for him to go to from the Satterfield home.

Q And, all these attempts to place him in St. Joseph's [58] and the Ethyl Harp's Home all preceded your sending him to Central State Hospital?

A Right.

MR. LACKEY: That's all.

(Deposition concluded.)

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR EUGENE C. JARRETT, III, taken on the 4th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The signature of the witness was specifically waived by his attorney of record, DOROTHY Y. KIRKLEY, ESQ.)

EUGENE C. JARRETT, III, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A Eugene Coleman Jarrett, III.

NOTE: (Defendant's Exhibit Number One was marked for purposes of identification.)

Q Would you identify Exhibit One, please, Doctor?

A This is my curriculum vitae.

Q And you are a pediatrician, is that correct?

A Yes.

Q Are you a psychiatrist as well?

A No.

Q What is your present position?

A I am the superintendent of Southwestern State Hospital.

Q How long have you been superintendent?

A Since September 19th, 1973.

Q What is your role and what are your duties as superintendent of the hospital?

[3]

A To administratively oversee the programatic functions, with the programs directors to develop various treatment programs that the hospital is responsible for providing to the citizens.

Q Since you are a pediatrician, are you also the medical director?

A No, Doctor William Bailey is the clinical director. Doctor Bailey is a psychiatrist.

Q Okay.

NOTE: (Defendant's Exhibit Number Two was marked for purposes of identification.)

Q Would you identify Exhibit Two, please?

A Exhibit Two is a computer printout of information relative to patients admitted to Southwestern from its opening in 1966 till the present time, patients under eighteen years of age, with their dates of admission, date of birth, primary diagnostic code, and the type of commitment and their discharge date or whether they're still an in-patient, is there also included on this list.

Q And when was this list prepared, Doctor?

A This list was prepared approximately the middle of November, but up-dated Monday, which would have been December the 1st.

Q Was it prepared at the hospital?

A Yes.

Q And who in the hospital was responsible for getting this information?

A The department of administrative services unit, which operates a computer at the hospital developed the computer printout. The medical records section, along with my administrative [4] assistant, brought the whole listing up to date.

NOTE: (Brief off the record.)

A I might clarify on that, that those with no discharge date or no indication as in-patients, were not correctly listed on the computer. Only those with complete information were complete.

Q You mean there were some listed on the computer that weren't actually there?

A No, the computer read things—was not properly programed, so some of them are listed multiple times, the same patient. Some of them were admitted over eighteen, so forth and so on.

Q Did somebody go back and double check, and that's how you found that out?

A Yes.

Q Is that correct?

A Right, each patient was checked individually.

NOTE: (Brief off the record.)

Q All right, Doctor, would you explain again, the process by which the information on Exhibit Two was derived?

A We requested from the department of administrative services, computer section at Southwestern, a listing of patients admitted to the hospital under eighteen years of age. This listing was obtained and in cross checking, or double checking the entries, errors were found. These errors have been corrected on the computer listing. Basically any line listing, or any entry of a patient, date of admission, date of birth, diagnostic information, commitment code and discharge date, has been verified. Those with discharge dates, commitment code changes, reflect corrections of the originally received computer information.

[5]

Q And seventeen is the commitment code for voluntary patients under age eighteen, admitted by their parents, is that correct?

A Correct.

Q And have you double checked to make sure that all of the seventeens show up on this list someplace or another?

A Right, as best we can determine, they're all here, through our double, and in several cases, triple checking.

Q And that—the double and triple checks were done manually, is that correct?

A Yes.

Q Would it be possible to have the computer program corrected?

A Yes.

Q How long would that take, do you know?

A I really can't answer. I might mention, also, that some patients were admitted to our hospital prior to our having a child and adolescent program, their need for children's services being obtained then, through the program at Central State Hospital, their discharge date may have been from that program, and it's indicated as "Discharge CSH" and the date.

Q Would they have been transferred back to you?

A Not necessarily at that time.

Q You mean you—for a part of the time your child and adolescent case load was physically at Central State Hospital?

A Correct.

Q And so they would handle the discharge?

A Yes.

Q How long has the child and adolescent program been in operation at Southwestern?

[6]

A We began efforts when I arrived in September, '73, to obtain a program—funding for a program. We obtained this through a Federal grant. After training staff, the patient admission aspects began in April of 1974.

Q Do you have separate child and adolescent units, or is it all one unit?

A One unit.

Q And how many patients?

A We have a maximum capacity of twenty patients. We presently have twelve patients.

Q Doctor, what are the general admission procedures used for children and adolescents?

A Very simply defined, the child is admitted through a community program. To explain that further, it is our feeling that children should not simply be admitted directly to the hospital with no definite effort put forth to take care of the child's needs in the home, not only for the child's benefit, but because many times the child's problems are an integral part of a family problem situation. So any referral for admission is first of all processed, or evaluated, by community mental health people, and then, if institutional admission is to be considered, the institutional staff is involved in a final determination of what the treatment plan will be for that child, and that

child's family. It may then include a short term admission, or an admission to an institution for the child.

Q Okay. Do you ever admit children without them having previously been seen by a community mental health service?

[7]

A We have not at this point. I can't, of course, say what the future will bring, but we have received direct referrals from Juvenile Courts, Department of Family and Children Services, and other individuals. Our first step is to get the community mental health program, child and adolescent representatives, to hook them in with the referring agency or individual, to initiate this evaluation prior to admission. Or prior to a consideration for admission.

Q As superintendent of the hospital, what is your relationship with the community mental health programs in your area?

A Very close, really. We are working on and have worked—succeeded to various degrees, with a similar process of this as far as adult patients are concerned, also. We have a very close working relationship with the community mental health in all areas of our service area.

Q Are you familiar with what the evaluation process would be in a community mental health center?

A For the children?

Q For the children, yes.

A This would include a social evaluation of the home situation, possibly—probably an evaluation of the child's school situation, psychological testing to indicate—or as

part of the evaluation. The social evaluation would be a look at the family, its arrangements, interactions, financial needs, and everything, and out of this would come, really, not just a plan for the child, but more than likely a plan for the whole family, as an effort to help the child.

Q Do you know in what percentage of the cases the family as well [8] as the child, is treated in the community program?

A I can't give you an exact percentage, but I would—from the cases that I have reviewed in our program, I would say better than ninety percent, if there is a family. I think with all of the cases we have now that have families, that the family members are involved in some kind of community mental health program, while the child is in the hospital and returning home.

Q What efforts do you use to make sure that the parents are involved in the treatment program?

A Varying efforts, really. First of all, it's just to try to help them understand why the need is there for this to happen. If this is unsuccessful, and if all the members of the helping agency group that are involved with the child, see the family as resisting, then they would become involved in whatevery way is appropriate to make sure that the child's needs are met. And the Department of Family and Children Services is frequently involved in this type of situation.

Q What would their involvement be?

A Well, they would be sometimes the referring agency for the child to begin with, they might be asked for assistance for the family if the mental health people saw the family needed this and the family had not been able

—had not obtained help before. They would be brought in as an additional assistance group to try to help resolve some of the family's problems. If they see the family as not being the proper place for this child, then, of course, it is part of their responsibility to work to correct this, and on some cases, it has meant that the child—D.F.C.S. has, with the assistance of the Juvenile Court, helped the child to [9] find a better place to live, and this has been a part, then, of his betterment of his mental health situation.

Q After the evaluation takes place at the community mental health center, is an effort made for treatment to be given to the child at home?

A Yes. This is the whole thing most of the time. The evaluation occurs there and the treatment is initiated and accomplished there. That's why I mentioned earlier that only those children, where institutional care and treatment is thought to be—or going to be a part of the child's need, will the hospital staff become more intimately involved in this pre-admission planning. Now, they may be brought in as consultants on cases that will remain in the community, but they are always part of the pre-admission planning for any child, where this institutional admission is to be considered. In some cases, the institutional admission will never occur, because the final outcome of all the planning is that it can be accomplished in the community, and it is accomplished there. But before the child gets to hospital, everybody to be involved with his case has been involved, and agrees with the decision to be made, and has been a part of the development of his treatment plan.

Q Just in a general way, what factors would enter

into a decision to hospitalize the child, rather than trying to treat him at home?

A Oh, certain things such as medical needs. You many need the child—if he is overtly psychotic, it may be that the medical decision that he needs to be in a situation where he can be watched extremely closely while medication — medical treatment [10 "A"] is inititated for his psychosis. And once he is stabilized, then he would be returned—once the medication regimen is stabilized, he would then be returned home to continue this. It may be that the family situation has been so disrupted or disruptive to members, that a brief separation is necessary to allow the community people to help the parents to begin to learn how to deal with the child while the child is in the institution, treatment routines are established to be applied in the home. Sometimes separation is just necessary to begin to get an accurate view of the situation and to develop a treatment process.

Q Would that last factor be particularly prevalent in cases of behavior disorders?

A I can't really say whether it would be more prevalent with behavior than with psychosis. It would occur more often, because there are more behavior disorders than there are true psychoses, probably.

Q Do you have any rough idea of the percentage of children admitted with behavior disorders?

A In our program at the present time, it would have to be an estimate, but probably eighty percent of our program, patients thus far, have been behavioral disorders as opposed to psychotic children. What we think we see is the program becoming better known through the region, more psychotic children are gradually increas-

ing. Maybe they're better identified, or whatever the reason may be.

Q Do you know what the average length of stay is on the children and adolescent unit?

A At the present time it's around sixty days.

[10 "B"]

NOTE: (Defendant's Exhibit Number Three was marked for purposes of identification.)

Q Would you identify Exhibit Three, please?

A Exhibit Three is information copied from the records of the patients in the institution under eighteen years of age on December the 1st, 1975. This is not a complete chart, but what we felt would be pertinent portions of the chart.

Q What does it include for each person?

A It includes the admission summary, which is the face sheet, including administrative and other data; it includes the referral form which is used by the community to refer patients to the in-patient program at the institution. It includes a psychiatric admission note; it will include a social service summary; and it will include other things depending upon the individual case, the treatment team meetings, treatment plans, progress notes, and a discharge summary, if the patient has been in before and is returning, and information of that type.

Q Okay.

NOTE: (Defendant's Exhibit Number Four was marked for purposes of identification.)

A I might mention I have indicated that two of these patients, in the upper right-hand corner, it says two

hundred not in C&A, these are individuals who are seventeen years of age, and because of their maturity, they are not housed in the child and adolescent program.

Q Are there some seventeen year olds that are in the child and adolescent program?

A Not at the present time. The program is basically limited to [11] children sixteen and under, but with the flexibility that if you have a child who is seventeen, or even older than that, possibly, whose physical maturity and personality maturity is not to the point where he should be involved in the adult program, he would be involved in the child and adolescent program.

Q Would you identify Exhibit Four, please?

A Exhibit Four is briefly described, a referral process for community mental health programs to use in the referral of patients for admission consideration.

Q And it states in writing basically the policies we've been discussing, is that correct?

A Correct.

Q Once a child is admitted to the hospital, what type of reviews are made of his case after admission?

A The treatment team, which includes not only people at the hospital, but also child and adolescent representatives in the community, would be involved with this child and his family. They review the child's situation minimally of once a month. The hospital treatment team reviews the child's situation minimally once weekly. These reviews follow an outline—follow—reviews of the child's treatment plan, which is developed according to a specific outline, to assure that all the parts are covered. This review, will, in the course of the child's treatment,

include his progress relative to visits home during the institutional stay, as well as his progress within the institutional program.

[12]

Q Now let me understand, there are two separate reviews, one conducted with community staff involved, and one conducted by the hospital staff?

A Correct.

Q And the hospital staff reviews are at least weekly?

A They will be more frequently than the total team review, because of travel and other problems in getting the team together—time problems; but that's correct. The team involved intimately with the child in the institution reviews the plan weekly. The total team, which is the team involved with the child's family as well as the child in the community, and the institutional team, review the whole situation minimally once a month.

Q Is there ever a review conducted by hospital staff that are not directly involved in the case?

A Not at the present time. We are trying to work out some mechanism to accomplish what is commonly called utilization review, where third parties, or non-involved representatives, review the programs, not only in this situation, but in others. The only outside review at the present moment, would be the Division of Mental Health staff members, who would review the function of the whole child and adolescent program. This occurs minimally once yearly, when the grant for the program is reviewed for renewal, and more often depending upon their travel capabilities to visit the institution.

Q Would they review individual cases at that time?

A As part of this, yes. They would not review every case, but could select cases at random for review.

Q Would they particularly select cases that have been there for [13] any length of time, longer than six months or longer than . . .

A Not necessarily. Of course, we don't have any cases of that type at the present time. I don't believe we have any child that's been in this program six months.

NOTE: (Defendant's Exhibit Number Five was marked for purposes of identification.)

Q Would you identify Exhibit Five, please?

A Exhibit Five is the outline followed—to be in the development of the patient's treatment plan.

Q Okay. While a child is an in-patient, is his family still being treated in the community?

A Yes. The family is involved in treatment in the community, the child will go home and stay with the family on weekends as often as is possible. What we have in some cases, is the child stays within the hospital program Monday through Friday and goes home every weekend. This is two reasons, one to maintain the involvement of the family with their child; the second reason is to be able to assess the progress that the child is making —and the family is making in being able to deal with the problems that they have to deal with, and modifying the treatment programs as indicated by the success or lack of success on these visits.

Q Do you find in general, a reluctance on the part of parents to take their children out of the hospital when the staff recommends this is the best plan?

A No, not really. Not if they understand that this is the way the program runs at the very beginning. The exception being, of course, the parent who does not wish to have the child in [14] the home to begin with. This type of problem would be identified in the evaluated phase, attempts made to work with it, and if it cannot be resolved, it might be a situation where another family might be better for the child.

Q So what steps would you have to take if that situation arose?

A This would be taken by the Department of Family and Children Services through the Juvenile Court system. They would have been involved, in other words, enough with the case to know the necessity of this action.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Six was marked for purposes of identification.)

Q Would you identify Exhibit Six, please?

A Exhibit Six is a very brief description of the child and adolescent program for this twenty-four counties in southwest Georgia that we are responsible for.

NOTE: (Defendant's Exhibit Number Seven was marked for purposes of identification.)

Q What about Exhibit Seven?

A Exhibit Seven simply defines some guidelines which we—which are used in our involvement with the psychoeducational center program in that area. The psychoeducational center being the community educational program for children with emotional and other problems. We have a teacher within the child and adolescent unit at the in-

stitution, but the patients—is an attempt to assure that, as part of their treatment, we feel that they need to be involved in an educational program. So we have the in-patient program as the—for those who cannot [15] compete in any kind of community program, and then as soon as they are able to leave the institution educational system, they go to this community program; as soon as they can leave that, then they go to a special education program in the—in a public school in the area; all of this being preparatory work to try to help this phase of their development, so they will be able to easily re-enter their school system when they return home.

Q One of the contentions in this case, Doctor, is that voluntary admissions of children to hospitals should be preceded in every case by judicial proceedings. Is it your opinion, as superintendent of a hospital, that judicial proceedings in the admission of children would be beneficial?

A No, I don't really think so, not with the system, particularly, that we have in operation here. What we have found, is that when we have been contacted by the juvenile authorities, when they found that there was available for their use, community mental health assistance for this child and this family, that they were pleased to know this, and used it, and use it appropriately. They can be of help, of course, when judicial assistance is necessary to get things done that need to be done, but I don't feel that in every case they need to be involved.

Q As a pediatrician, is it your opinion that judicial proceedings might have any harmful effect on children?

A That's a difficult question to answer, really. If the judicial proceeding involves trials, court appearances, things of this sort, then I certainly feel this could be very

frightening to the child, unless handled in a definitely very appropriate [16] manner. Children see things — maybe based upon what they see on television and in movies, but they do have opinions or thoughts about court and what all court involves. And a court hearing can be handled in such a way that it does not frighten the child, I'm sure. I also think that it could be handled in a way that would frighten the child and could actually aggravate problems rather than help them.

Q Have you attended any judicial proceedings yourself?

A No.

Q So you're not . . .

A So I can't—as I said, I can't really answer the question but just except my own personal feelings.

Q That's all the questions I have.

EXAMINATION BY MR. GRANBERG:

Q Doctor Jarrett, you were saying, when we had some problems about this computer printout, I think you said it was originally incorrectly programed, is that right?

A (Nods in the affirmative.)

Q I just want to ask you about a couple of them—of the things that are on that in regard to another statement I believe you made later. I'm not—I don't want to put words in your mouth. I believe at one time you said the longest anybody had been there, the present people, is six months?

A In the present C&A program since it developed in April of '74.

Q The longest anybody has ever stayed is six months?

A In the C&A—no, I don't think we have anybody in the C&A program that we have, who has—that have been in it for six [17] months. Now we may have, in the older patients in the hospital, people who might have been admitted under eighteen, who may have stayed in the institutional program for more than six months.

Q Okay. Do you know—there may be people who were admitted under the statute—the statute we're talking about, when I refer to that, will be 88-503.1, the voluntary admission statute, . . .

A Right.

Q . . . that there may be children in there who were admitted pursuant to that statute, before the children and adolescent unit came into being . . .

A Right.

Q . . . who are now in the children and adolescent unit?

A We have one boy that you have information on that is in that program now, that had been admitted to Central State, and I think had been admitted to Southwestern, prior to having the child and adolescent program. But of those in the program now . . .

Q Now, let me just—I think this is one—maybe you can explain it . . . Okay. What we are referring to is one of the pages on the patient listing, and if you could just look at that for a second and tell me if—is this person now in the C&A unit?

A Which one are you pointing to?

Q This one right here, I'm sorry.

A This one right here?

Q Yes.

A That person was discharged June the 27th, 1975. The next one [18] should be an in-patient.

Q I'm sorry, I meant—I was referring to 3322.

A Okay. That person would have been admitted November the 22nd, 1972; this person would be an in-patient now. This person is not in the C&A program according to her birthdate.

Q I see.

A She would be seventeen, I believe, so she would be on an adult unit.

Q Okay. Would you just look at this one and tell us about that. I think this is it, 3534.

A Okay. That's an in-patient—this is a mental retardation diagnosis.

Q Okay, that was our mistake. That was the wrong number. Okay. But there are—I don't want to over-state this, but there are people, then, who were admitted pursuant to the statute who have been there longer than six months, and are somewhere in your hospital, and are under, at the present time, eighteen? For example that one—the first one that we just discussed. She may not be in the C&A unit, but she is under eighteen, she is in the hospital . . .

A According to that data that's correct, but I'd have to calculate her birthdate to see whether she is still under eighteen or not, because this information here is supposed to be only the patients that we have . . .

Q Okay. Without trying to pin you down too much, is it possible that there are people who were admitted—children admitted under the statute and are now somewhere—not necessarily the C&A unit, but somewhere in your hospital, and are under eighteen?

[19]

A It is possible, but I would say that these would be people who are over the age range for our present C&A program; in other words, seventeen.

Q Why is the cut-off sixteen? I guess I should—up to sixteen. Why is it . . .

A At the age of puberty, many things change in additon to a person's physical being. Attitudes change along with this, personalities change, and do forth. In our efforts to develop a child and adolescent program, since it is small, and since we didn't have any funds to develop the broad range thing, we felt that it would be necessary to try to keep the population in the program, one that would not be disruptive to itself, in other words. And to mix too many different types of people together, we felt would mean that the patients themselves would be detrimental to one another.

Q I can understand that premise, or the dichotomy there, the cutoff line.

A That's why I said earlier, too, that though the program states, I think, on the program description, generally sixteen or under, something of this sort, we retain the flexibility within the program to have anyone, even eighteen or—theoretically, even older than that, whose personality is being—is more in keeping with a child or adolescent program. If that type of treatment is what they need, then we have no hard and fast rule that says they cannot be included in this program.

Q No age limit at all. Do you have any—do you have any people now who are seventeen years or older in the children and adolescent unit?

[20]

A I think we have one boy who is either seventeen or almost seventeen.

Q Okay. Have you had any, let's say, in the last six months with the exception of that child? Have you had any children seventeen or older in the children and adolescent unit? Or in the last year?

A Right. I can think of one child that I think was seventeen. Others, the program staff has been involved with, they may be living on an adult unit, but coming to the child and adolescent program on a day basis.

Q Assuming, then, what we were just talking about, would it be fair to say that although the program—your hospital does say that it has no end limit to the people who could be in the children and adolescent unit, if doctors—physicians deem that treatment there would be most beneficial to that person, that there have been none, or few, children—children or adults seventeen years or older who have in fact been admitted as full-time patients to the children and adolescent unit?

A Few, correct.

* * * * *

[24]

* * * * *

Q Let me ask you a few questions about your specific institution—hospital. What is the total number of people, approximately, in the hospital right now?

A Total number of in-patients would be about five hundred and ninety.

Q And—so right now there are—how many people in children and adolescents, approximately?

A Twelve or fourteen at the present moment.

Q And the other ones are adults, voluntarily committed or involuntarily committed?

[25]

A There would be adults, both voluntary and involuntary, and mentally retarded—we have one unit for mentally retarded, a hundred and twenty beds. This is for individuals who have medical nursing care needs, physical handicaps of a severe degree.

Q I see. The—in regards to your staff, how many physicians do you have, the number of physicians?

A Presently on board we have fifteen, I believe it is.

Q Now on board, is that a term of art . . .

A That means working.

Q Okay. The doctors, how many of them are licensed to practice in Georgia, do you know?

A Nine.

Q And then the remainder are—I forget, Doctor Skelton yesterday gave us the correct terminology . . .

A They have a limited license, institutional permit.

Q Institutional permit.

A To practice within the institution.

Q So is that true, that the remaining six have an institutional permit?

A Yes.

Q Do you have any American Board of Psychology and Neurology certified psychiatrists?

A No, all of our psychiatrists would be what are called board eligible. They are not board certified.

Q Do you have any child psychiatrists there?

A No, we have one consultant child psychiatrist, who consults on particular cases.

[26]

Q Who is he attached with?

A He actually comes from the University of Florida at Gainsville Medical Center.

Q How long has he been there?

A Not very long. I can't recall exactly how many visits or how long. It's just been within the last, say, six months, probably.

Q On the staff, are there any foreign born or foreign trained physicians or psychiatrists?

A Yes.

Q How many would you say foreign trained phychiatrists are there?

A Two.

Q I don't know if I asked this, please forgive me if I'm repeating it, but how many psychologists—psychiatrists are there?

A There would be—as I mentioned earlier, the clinical director is a psychiatrist, we would have five.

Q Five psychiatrists?

A Uh-huh. (Affirmative.)

Q And two of those are foreign born or foreign trained?

A Well, not totally foreign trained. One of those was trained at the University of Virginia. His foreign medical school training was in the Philippines, but did his psychiatry residency in this country.

Q And the other?

A He did his—if I can remember his credentials correctly, I think he did his psychiatry training in the Philippines, but has also done some work in this country.

Q So both of them are—both doctors . . .

[27]

A Partially, right.

Q And how long have they been there?

A Oh, just two or three months.

Q Are all the psychiatrist—I should say, how many people are involved with admitting children to the hospital under the statute which is the subject of this litigation?

A Okay, at the present time, as mentioned, the referral system we now have in place for children, would require that the community mental health people be involved, their psychiatrist, Doctor Middleton, who is a psychiatrist for this program, and so forth. In other words, the whole treatment staff would be involved in the admission decision. So it would not involve, generally speaking, anybody except the child and adolescent people.

Q Well, who actually makes the decision? I mean, does one person make the decision on the advice of others, or is it a two out of three, or something of that nature?

A It's not put to a vote, I don't think, but the decision for admission must be made, in the final analysis, by a physician according to Georgia law as I understand it. The physician, . . . in an interdisciplinary team approach to evaluation and treatment, so the physician participates as a member of this team. He has the authority to over-ride any decisions which, in his medical judgment, are inappropriate. So if I understand your question correctly, the physician would do this.

Q And all of the fifteen physicians on your staff are able, not only on qualifications, but by the way you've got them on the staff, be able to admit people? I mean, is anybody especially [28] assigned . . .

A Theoretically, yes, but in actual fact, with this program, if they receive a referral for a child at night or on weekends, then they will either refer this child to the child and adolescent program for the evaluation regarding admission, or will call in the people in the C&A program on call to assist them with handling the situation appropriately.

Q So no decision to admit is ever made by . . .

A By whomever happens to be on call?

Q Right.

A It's difficult to say something never will happen, but in this case I think I can say yes, that's true.

Q How long has this team approach to admissions been in existence?

A Since the program began in April of '74. It is being further clarified and developed, of course, as the new people get experienced.

Q It sounds, from what you're talking—your general description of programs—you have a pretty close working relationship with these mental health centers?

A Right.

Q And do you know which or what—what the staff consists of in each of those institutions, or . . .

A Each community mental health center has a specific component of their staff defined as a C&A—child and adolescent—representatives. These are the people that directly interact with the institutional staff. These are the people that are responsible for either providing or seeing that services for families as needed as part of the C&A program are obtained. [29] I can't give you the specific backgrounds on each of these individuals.

Q Well, you did mention like Doctor Middleton?

A Doctor Middleton is the director of the Archbowl (Phonetic) or Thomasville Community Health Center.

Q And are there psychiatrists in each mental health center?

A Each mental health center has a psychiatrist as a member of their staff. There are—I do know with the Thomasville Center there is a Ph.D. child psychologist, a child psychiatrist social worker, a recreational activity therapist-type person involved with their child and adolescent program. In the Valdosta Center, I believe their chief representative is a—I think he's a social worker—two social workers basically make up their key team members.

Q Okay. Let me just ask you, just pick out any of the counties—like if somebody wanted to—a parent or

guardian wanted to admit his child to the institution, and he called up your hospital, just what would happen?

A If he called our admissions office, which I would assume would be their contact point, since it's listed in the telephone directory, then the admission person who received this call, in gathering the information would recognize the fact that this was a child. They would then ask the people to hold while they transferred the call to the director of the child and adolescent program, or the staff member that was handling—receiving calls if the director was not in place at that moment. These people would then gather the information, talk with the parents, and then make an initial assessment as to where things needed [30] to go from that point, which as a general rule would mean that they would tell the person that someone would be in contact with them shortly. They would then contact the community mental health center representative for that area, and that same day they would begin to receive some contact from the community, initiation of the evaluation process. On occasion, the paramount need might be in something other than mental health. If this were the case, then this worker would also make contact to another helping agency, or what other group needed to be involved with this family as well, now instead of, but in addition to.

Q Okay. Let's say they still felt—the parents still wanted the child to be admitted to the hospital. Would the psychiatrist or some physician at the community mental health center then interview the child?

A Oh, yes, the child and the family would be evaluated by the community component of the system.

Q And that will always happen, they won't come directly to the hospital . . .

A Theoretically, this is the way it's set up, this is the way it has worked. Now on occasion, I can imagine someone . . .

Q I'm talking about non-emergency situations.

A Okay, yes, this definitely is the way it works now.

Q It sounds like, then, that your staff is in pretty frequent contact with the people at the various mental health centers?

A Right.

Q Do you know if a psysician, or a psychiatrist, whoever it is at the mental health center, that would say, yes, this child needs to be admitted, would that decision be—generally [31] followed by the hospital admitting crew or team, at your hospital?

A I would have to say generally I suspect it would be, because this decision would have been made, again, by the teams together. The pre-admission planning requires that the hospital staff is involved with this community group in determining the child's needs, and whether or not the hospital program has the capability to address these needs.

Q Okay, let's say we've got the recommendation at the community level, and then the child would be referred to the institution—to the hospital?

A Right.

Q And at that time a separate interview would be conducted by a physician at the hospital? Or would a team meeting then take place?

A A team meeting would have taken place prior to the child's coming . . .

Q I'm sorry.

A . . . and then further, after the child is admitted, more detailed, more in-depth work continues to go on, the development of a treatment—modification of a previously developed treatment plan and so forth and so on.

Q Okay. I just want to make sure I have it straight for admission. Pardon me if I'm repeating things. If the doctor recommends—from the mental health center, that the child should be admitted, then does a physician or psychiatrist from the hospital go on out to the mental health center and do the—does he [32] meet with the team at the mental health center?

A The psychiatrist? Not necessarily.

Q Essentially what I said, is the one who eventially puts his name on the admission sheet at your hospital . . .

A He will not necessarily, in person, interview the child in the community. He will have reviewed all of the data that has been collected on the child and the family situation and so forth.

Q Okay. I'm going to try to summarize some of this, and if it's incorrect, please stop me. A child comes—parents come to the mental health center or to the hospital—they're at the mental health center or the hospital refers them to the mental health center, there is an interview then, by a physician at the mental health center to determine whether—what the problem is, and what type of—whether recommendation for admission should be made, the . . .

A The physician and other staff.

Q Okay, who would the other staff be . . .

A It would be social workers and psychologists, generally speaking, to do psychological testing, social assessment of the family and so on.

Q The psychologist would probably do the testing about the time they did the interview, or . . .

A Not necessarily the same day. In other words, the evaluation process in the community may take several days, or longer.

Q It could take a while, then?

A Oh, yes.

Q I can understand your concern — obviously you show concern [33] that the child not be admitted just for any reason.

A Uh-huh. (Affirmative.)

Q Okay. So you've got a—this thing going down at the community mental health center, and you've had a psychological test. The social workers—I don't know what you call them—whatever they are, who are connected with the center, I imagine they go in and look for secondary information from schools, neighbors, relatives and things like that?

A Correct.

Q And then they would write up a report and give it to the psychiatrist or the physician at the mental health center?

A Yes, the team involved with this case would review the case, all the findings and everything would be discussed by the team in a conference, so to speak.

Q Do you know what order that would happen? Would the interview of the child by the psychiatrist take

place, and then information gathered by the social worker, or would the psychiatrist make his decision or recommendation based partially on the interview and information he has received previously from the social workers?

A My assumption would be that it's based on his interview and the information—additional information he had received.

Q But you don't know what chronological time sequence that occurs in, do you?

A No, I don't.

Q Okay. So then at that time you've had—the team meeting would be the three people there and whoever is—whoever is in [34] contact with them, either physically or by telephone, or I guess by even letter, at the hospital. And that would be just one person, the psychiatrist at the hospital?

A No, it could be more than one person. This would be one of the functions of the at least monthly meetings of the hospital and community staff together, review of current patients and review of problem cases where institutionalization might be considered.

Q I'm only talking about admissions, now.

A Well, this would be a combined staff function.

Q Okay. So there could be, in an effort to make sure that the—apparently to make sure that the child's treatment plan fits his particular situation, there could be a pretty good passage of time before the decision to admit is made, not for the purpose of delaying it . . .

A Possibly.

Q . . . but for purposes of making sure.

A Correct.

Q Okay. Would—considering—I would also make the assumption, then, that you—the hospital and the community mental health people that you work with, consider it extremely important to get as many facts, or as much information about the case, both the child and the family, as possible, before any decision is made as to either diagnosis or admission?

A Correct.

Q Then assuming the thoroughness of the plan, would the admission procedure to the hospital be burdened in any significant degree, let's say, by the intervention of a third party, an independent [35] third party like an arbiter, or even a Probate Court Judge, or a Judge, at which point all of this information could be set in front of him, realizing, of course, what you previously said on direct about your qualms about judicial hearings.

A The only thing that you've already said, is that this is an additional step, which would, of course, take time. As far as I'm concerned, in this program, there would be nothing to hide. I don't see anything to be gained, really, either.

Q Well, don't get me wrong, I'm not trying to say—I can see your concern, and I'm not trying to say that we—we're suggesting this because you're trying to railroad a child, but considering that—could you agree with me that it's also sometimes very helpful—like you talked about the team review, you must agree that it's good to interchange ideas and facts, because of your team approach.

A Uh-huh. (Affirmative.)

Q And it might--and since the admission process can sometimes take a while because of your concern that—a situation where the people from the hospital got together with the other people from the mental health center, could also be an avenue for an exchange of ideas, information and perhaps, discovery of alternatives which maybe they didn't know existed, and this independent arbiter, Judge, Probate Court person, somebody else could say, maybe this exists?

A If I follow what you're saying correctly, in many of these cases these people are already involved, because the referral may have come from them to begin with.

Q Surely.

[36]

A And they have referred the case maybe because they did not have the answers, and they needed the assistance provided by the mental health component.

Q I guess what I'm getting at, assuming that they don't have the expertise off-hand to make a decision, you know, even if they didn't have the priority or jurisdiction to make that decision, but assuming if they did have that power, would it hurt if, you know, if they say that the court referred somebody—tried to get as much information as they could, and say, as a matter of protecting the child's liberty, we're going to hear everything that's possible about it, an exchange of ideas, information, diagnosis, analysis, would that really seriously disrupt or disturb the present procedure that you have?

A I don't think so, because it already occurs. In cases where they need this information, then they obtain this information. Again, I'm not exactly sure I understand what you're saying, but if the Juvenile Court needs certain types of information in order to make a decision, for example, to take custody of the child, or something of this sort, then they have access to this information then.

Q But I'm talking about—okay, that's the thing I was assuming, because as you know, right now there is no court or judicial intervention in this process at all, or even anybody from outside of the system, that's what I meant, only in that context.

A Right. But in that case, I don't see, personally again, and I think I said it earlier, too, the necessity for judicial involvement with every case.

Q Okay.

[37]

A Because we hope our—one of our primary efforts is to build in protections for the children to prevent them from being abused by any system.

Q If I'm not mistaken, there are usually no psychiatric —separate psychiatric examinations or interviews conducted at the hospital of the patient prior to admission?

A No, not prior to admission, nothing than already has occurred . . .

Q Do you know, considering the in-depth working knowledge that you do have of the various mental health centers, whether there are any written policies in the mental health centers in regards to—written or unwritten policies, in regards to what should the—what the psychiatric examination should consist of? For example, like the length of the interview by the admitting physician, or the physician at the mental health center?

A I really don't know if they have any policies of this type.

Q Okay. How, for example, verification of information gathered from secondary sources? Do you know if they have any policy . . .

A I can't answer that.

NOTE: (Brief colloquy.)

Q Of if they have any policy in regards to the verification by the team—team members of information given by secondary sources or parents, teachers, and things like that?

A Do you mean . . .

Q Do they have a system . . .

A If the child's aunt says such and such happened . . .

Q You have to go to some other source to find out—or anything, [38] to check on the verification—to check on the correctness of the information?

A If you're saying whether or not the social worker's findings would be corroborated by findings of another person or something of this sort?

Q Or that what the social worker got from another person, the information he or she . . .

A Fits in . . .

Q Yeah, and would that be corroborated by anybody else, as a matter of policy? And it may very well happen, but as a matter of policy, is it required?

A I can't truthfully answer yes or no.

* * * * *

[40]

* * * * *

Q . . . sometimes it is family strife, or family stress, family problems that lead to the admission of a child—the request to admit a child?

A A disturbed child in the family can disrupt the family, or the child's problems may be brought about, possibly, by the family strife and so forth, so the point I think I was trying to make was, rarely, if ever, will you have a purely emotionally disturbed child in a family with no other problems there. So almost without exception, we're talking about family involvement in the child and adolescent program.

Q Could you see, then, that there is a possibility of potential conflict between the parent and child, if the parent is requesting admission to the hospital for the child?

A On occasions, possibly potential conflict, yes.

Q Never any conflict, though, between the parent and child—parents and child or guardian and child?

A Certainly. The—that may be part of the family strife situation. It has to be resolved.

* * * * *

[43]

* * * * *

Q Do you have any policies, written or otherwise, which began—like with the mental health people at the mental health center, which talk about how this admission procedure should take place? [44] For example . . .

A Where the parents would come with the child or so on and so forth?

Q . . . length of the interview, location of the interview, all of those things that I previously mentioned . . .

A No, because there is too much variation in this, if I'm understanding again, what you're asking, to say that an interview with a child should be fifteen minutes, or an hour and a half, or whatever.

Q Do you have . . .

A You can't lock it into this much specificity.

Q Certainly I understand that. I'm not trying to say that you have got this form, and you fill it out, and that's the only thing you do. Don't get me wrong.

A Right.

Q But are there policies as to what should be covered at the time—what subjects should be covered at the time—what subject matter, at the time of the admission?

A In the psychiatrist's interview with the child?

Q Yes, is there anything—any policy by the Southwestern Hospital itself in regards to that?

A Not to — not to indicate what the psychiatrist should interview the child . . .

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR WLADYSLAW P. MAZUR, taken on the 5th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
STEVE GRANBERG, ESQ.
Georgia Legal Services Programs
Macon Regional Office
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For the Defendants: DOROTHY Y. KIRKLEY, ESQ.
Assistant Attorney General
Department of Law
132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition, and he specifically waived that right.)

WLADYSLAW PIOTR MAZUR, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A My name is Wladyslaw Piotr Mazur.

NOTE: (Brief colloquy.)

NOTE: (Defendant's Exhibits Numbers One through Five were marked for purposes of identification.)

Q You brought some documents with you and I've asked her to number them as exhibits, so what I'll ask you to do is identify each exhibit and then we'll discuss it. Would you identify Exhibit Number One?

A This is my curriculum vitae.

Q And is that current?

A That is the current curriculum vitae.

Q And you are a medical doctor, is that correct?

A That's right.

Q Are you also a psychiatrist?

A That's right.

Q Are you board certified?

[3]

A No, board eligible.

Q You are board eligible. And what is your present employment, Doctor?

A I am the superintendent of the West Central Georgia Regional Hospital at Columbus.

Q And how long have you been superintendent?

A Since September 3rd, 1974.

Q Is that when the hospital opened?

A The hospital opened, actually, three months later on December 2nd, 1974, when we first admitted our first adult patient.

Q When were the first children and adolescent patients admitted?

A In May, 1975. The unit was opened on May the 5th, 1975.

Q And what counties, or what area, does your hospital serve?

A Our area serves the west central Georgia, which consists of twenty-nine counties, which are conterminous with D.H.R. district four, which is composed of two catchment areas, area eighteen and nineteen, and district seven, which includes area twenty-five and twenty-six, serving counties—do you want me to name all the counties?

Q No.

A There are twenty-nine.

Q Twenty-nine counties. And are there community mental health clinics and programs within this area also?

A There are.

Q Could you tell me where those are located?

A There is one in Columbus, one in LaGrange, in Troup County; one in Carrollton in the same area, in Carroll County; in Newnan, which is Coweta County, then there is one in Griffin, Spaulding [4] County; in Covington, in

Newton County; one in Americus, in Sumter County, with a satellite in Crisp County, in Cordele; and these are the main full-time clinics. There are some satellite clinics which operate on a once a week or twice a month basis.

Q Through these community programs, are all twenty-nine counties in your area served with a community program?

A That's right. There are counties which do not have any facilities. But those counties contract with those that do.

Q What about children and adolescent community programs? Would that be in each of the main clinics that you . . .

A In each of the main clinics, they are served—children are served by the clinics. Now in some counties, like in Muscogee, which is Columbus, Georgia, there is a separate child guidance clinic which is separate from the mental—adult mental health, but the other clinics handle that—without separating the two.

Q What is the working relationship between the hospital and these community clinics?

A Well, the community clinics now, as of September—October, '75, belong to a consortium. Each consortium is conterminous with the hospital region service area, and the mental health and mental retardation program directors in each catchment area, and there are four catchment areas in my hospital district, these people, we refer to them as geographic unit directors, who are in charge of the community services, those four unit directors plus the district health directors and a superintendent of mental retardation facility, are members of this consortium,

[5] the full name—our full name is the West Central Georgia Mental Health and Mental Retardation Planning Consortium, shortly Consortium Six. The main mandate is to assign priorities to plan for budget and so on, so we are functionally acting in unison toward the common goal of providing a unified system—by unified meaning where the out-patient services and the in-patient services are acting in concert, rather than opposite ways.

Q Now would you explain the admission process to your hospital, with particular reference to children and adolescents?

A Well, first of all, there are two kinds of admissions. If it is a court ordered admission, there is no question about it . . . If it is a request from a family, or a recommendation from a school, then we evaluate the need for hospitalization. And of course, we have only less than twenty beds available, this process of screening is very, very thorough, because there is more demand than we can respond to in the way of providing in-patient treatment.

Q Are the evaluations performed right there at the hospital?

A Yes.

Q Do you ever refer an applicant to a community program for an evaluation?

A Well, some of them come via the local health—mental health clinic, but even then we still evaluate the need for actually having the patient on an in-patient basis. We prefer to find alternatives to hospitalization if possible, because of the shortage of beds, and because hospitalization is regarded as the last resort in treating a child. We prefer to treat the [6] child in the community,

preferably in its own family, unless the family is sicker than the patient.

Q Is there any policy, either formal or informal, that a non-emergency patient would be referred first to a community mental health clinic?

A Yes.

Q Is that written somewhere, or . . .

A I'll have to look into the—this book of policies and procedures. (Indicating Exhibit Three.)

NOTE: (Brief off the record.)

Q Would you identify Exhibit Number Two, first?

A This is a list by initial of patients who have been evaluated but not admitted.

Q Since when, Doctor?

A This is since—well, it would be since the unit was opened in May 5th, 1975, but the earliest date here is June, I think.

Q All right. Now, if you would identify Exhibit Three?

A Exhibit Three is the West Central Georgia Regional Hospital children and adolescent unit policies and procedures, which was written in September 25th, 1975, prior to the opening of the hospital for patients. And on page one we have the children and adolescent unit policy on referrals for evaluation.

Q And does that include a written policy that there will be a referral to the community mental health program?

A Yes, it does say here that a child or adolescent will be considered for admission by the clinical team of the

C&A unit in a screening evaluation session, which is to be scheduled by the unit's social worker. Where feasible the community worker referring the [7] patient is requested to attend the screening evaluation session in person with the patient, and where feasible, with the patient's parents or guardians. The community worker making the referral is requested to bring or send written information including any of the following available material: A psychological (sic) history, a developmental history and immunization record, a psychological evaluation, a psychiatric evaluation, a summary of previous treatment—of previous treatment approaches, recommendations for treatment at time of admission, and any proposals regarding plans after discharge.

Q You mean even before admission is made, there is a suggested plan for discharge?

A Oh, yes, this is the most important—this is the most important part of treatment, what are we going to do with the child after—after discharge, the hospitalization being regarded only as a last resort emergency measure which we try to keep as short as possible.

Q In the first paragraph here there is a distinction made between emergency admissions and other admissions?

A That refers to the, I think, to the court ordered emergency, or the non-emergency commitment. There are two kinds . . .

Q Are there any kinds of emergency voluntary admissions that you can think of?

A Well, yes, if the child is very disturbed and is suicidal or homicidal—there are homicidal children, so

that would be considered as an emergency. Wherever there is a life-threatening behavior, be it directed towards the child himself or herself, [8] or others, or things like fire setting, this kind of thing is always considered an emergency which warrants in-patient treatment.

Q Now in the non-emergency voluntary admissions, what kind of standards or criteria would be used in deciding to hospitalize the child?

A The main point is to find out how disturbing is the child's behavior to the family, the environment, and how dangerous is it. If none of these factors exist, then we try to treat the patient on an out-patient basis if possible.

Q Do you have any policies regarding treatment of the family at the same time the child is being treated?

A Yes. This is the basis of the approach, because wherever there is a sick child, there is usually a sick family.

Q Do you have any idea in what percentage of the cases the parents are treated along with the child?

A Oh, I couldn't give you off-hand any statistical data, but there is always an attempt to involve them very closely in the treatment plan and post discharge plans, because without their cooperation, whatever we do is useless.

Q Are you familiar with any cases in which the parents refused to have . . . treatment?

A Yes, we had a case where we felt the child was not the sickest member of the family. That was that the patient was previously hospitalized in the Central State Hospital, and through evaluation of the family backgrounds, we determined that the—it was actually the

mother who was the sicker—the sickest member [9] of the family, and they refused to—even to give us permission to obtain her records—her psychiatric records. This is the case that you're familiar with.

Q What action did you take in that case?

A We have asked for temporary custody in cooperation with the Children's Protective Service in Columbus, who were the initiators of the custody proceedings. We helped them to organize this case so that they could get the custody of the child.

Q Since the hospital has been open, is this the only specific case that you are familiar with?

A That is the only specific case that I'm familiar with.

Q How many children have been admitted to the C&A unit, do you know roughly?

A I'm sorry, I cannot give you that.

Q Will this be shown in . . .

A It will be shown in Exhibit Four and Exhibit—the one that gives the—this one.

Q Exhibit Four, is that what you're . . .

A No, Exhibit Four includes patients who are . . .

Q Does Exhibit Four include both your current patients and those that have been discharged?

A And discharged, yes.

Q Does Exhibit Three also describe the program . . .

A Yes.

Q . . . of the C&A unit in your hospital?

A Exhibit for admission—admission procedures, routine admission orders, medicine hours, standing orders, medical procedures, emergency screening procedures for evenings and weekends, [10] information on the children

and adolescents which deals with things like individual treatment, telephone calls, home visits, letter writing, passes and so on, the patient rules and regulations, the policy on patient rules and regulations of the childrens unit, privileges, restrictions and behavior modification, description of various levels of privileges that the patients may have, those which separates the patients that need to be under very close observation, from patients who, after repeated observation and orientation and treatment, may have gained much in self control . . . allowed privileges which encompass more responsibility, like going from the campus unattended. And then the highest level is a child with—that has additional privileges and responsibilities. This is in case when the condition for which they have been admitted has clearly improved. They may go to the stores and take bike rides on the campus. We do have donated bikes from the community. They may sign out for an unescorted walk, have weekends or longer than twenty-four hour passes, may go the snack bar unattended, and so on.

Q Do you have any idea of the average length of stay for children on your unit since it was opened?

A The average length of stay is of course, longer than the adult population. Now the adults average about twenty-four days. Now the children, it would be—I'm sorry, I don't have a computer to work with, but it is possibly even twice as long.

Q Can you think of any reason why it would be longer?

A Well, because when hospitalization of a child takes place, this is usually a much more serious situation than the adult popu-[11]lation. To remove a child from its home environment is a much more serious step than to remove an adult.

Q Okay. Doctor, do you have any periodic review at your hospital?

A Yes, I brought—brought the utilization review plan, the objective of which is the maintenance of high quality patient care and an increase in the effective utilization of hospital services.

Q Who conducts that review?

A The clinical director does.

Q Would there also be periodic reviews by the staff of the children and adolescent unit?

A Oh, yes, we do have a consultant—outside consultant who is not a member of the staff, Doctor Rains, who has practiced child psychiatry in the community of Columbus for a number of years, was a member of the staff of the Bradley Center and is now in full-time private practice in child psychiatry, and we have fairly recently—it was not from the beginning of the operation, but after about two months—we have retained his services as our consultant, and he comes once a week and reviews the cases.

Q Would he review every case each week?

A That would depend. Sometimes a review of a single case may take his entire visit, because they present to him the most problematic cases. We, of course, have our own staff who can handle the more routine matters, a pediatrician who is very well versed in the problems of—emotional problems of children and retardation and also drug abuse.

[12]

Q A pediatrician is the head of your C&A unit?

A No, the actual unit director is—is not a pediatrician. We have non-medical directors.

Q But the chief position is a pediatrician?

A Yes.

Q And there are twenty beds for children and adolescents?

A The unit was built as a forty bed unit, but the present austerity measures secondary to the budgetary crisis all over the world and in the United States and Georgia, permit us only to operate half of that.

Q Are you familiar with how often there would be staffings on each case? Weekly or monthly?

A There is a staff meeting every day.

Q Every day. Do you know if Doctor Rains reviews cases after they've been there for a certain length of time, say once a child has been there for, say, thirty days, Doctor Rains would begin to review their cases?

A I would think that . . . he may be called on the phone for consultation just at the time he evaluates the patients. There is no rule of thumb to that. We play it by ear, to utilize his services as effectively and efficiently as possible.

Q Are you familiar with any particular problems other than the one we discussed about the parents who do not participate in treatment? Are you familiar with any other parents who are reluctant to take their children back home when your staff recommends it is time for discharge?

A Not to my knowledge, no.

[13]

Q Okay.

NOTE: (Defendant's Exhibit Number Six was marked for purposes of identification.)

Q Exhibit Five is the utilization review policy, is that correct?

A Yes.

Q Now Doctor, if you would identify Exhibit Six, please?

A These are the legal papers which accompany each admission, be it voluntary or involuntary, the physical examination, the history and mental and physical examination. There is one that's a form and one that is written, and we have a social history too.

Q Is that for each patient that's currently on the C&A unit?

A Yes. And some of them include psychological consultations prior to admission, an interview . . . accomodations by psychologists and so on. The names are marked out on the usual places, but I can't guarantee that they have not—occur . . . in the text it should be.

NOTE: (Brief colloquy.)

Q Doctor, one of the primary contentions in this case is that there is a necessity for judicial proceedings prior to the voluntary admission of each child to a regional hospital. In your opinion, as superintendent of Columbus, do you think that it's necessary to have a judicial proceeding prior to every admission to screen cases?

A No.

Q And why not, Doctor?

A I don't think it's necessary, period. To require such is a reflection on the honesty and good will, competence of the [14] medical staff.

Q Do you feel that the current hospital procedures are adequate in screening cases?

A Oh, yes. There are more children that we turn out than we take in, because of the shortage of beds, for one thing.

Q That's all the questions I have.

EXAMINATION BY MR. GREENBERG:

Q Doctor, let me just preface all of these questions to say that when I refer to admissions, most of the time I'll be referring to voluntary admissions pursuant to the statute which is the subject matter of this whole litigation which provides that parents or guardians can admit children under the age of eighteen, so if you have any confusion or any questions about what I'm referring to when I talk about admissions, please let me know, because I don't want . . .

A You mean the voluntary admissions.

Q Yeah, most of the time when I say admissions I going to mean voluntary admissions . . .

A Not commitments by the Juvenile Court or anything like that.

Q Unless I specifically say it, and if you don't quite understand the questions, please let me know.

A Sure.

Q Let me just ask you very briefly, what is the present number of children in the children and adolescent unit?

A They are full, twenty.

Q Twenty. And how many of them are there pursuant to the voluntary admission statute, do you know?

[15]

A I'm sorry, I was not prepared to answer these kinds of detailed questions. It can be—it can be culled from this, because you have admissions here listed, number seventeen is voluntary admissions by parents or guardians, and most of them are seventeens, so . . .

Q Fine. Okay, that was my fault, that was my misinterpretation of this. I just assumed that first sheet of the Exhibit was all the people who were discharged. I apologize. Are the children and adolescents units separated? Is there some kind of dividing line between children and adolescents?

A No. Actually, we have—the majority are in the age group of twelve, I would say. The oldest child is sixteen, but there are but a few of them.

Q And they all reside in the same facility?

A They all reside in the same facility.

Q Are any of the . . .

A But it is a completely separate building from the adults.

Q There are no patients under eighteen who are in the adult facilities or wards?

A No. There might be occasionally.

Q Okay. I said—let me narrow that down. Then there are no patients under eighteen who are admitted pursuant to the voluntary admission statute in adult wards?

A Again that would be very difficult for me to answer that. When there is an individual who is just under eighteen, and who is requesting a voluntary admission, and we, of course, do not have enough space to hospitalize an eighteen year old, he's practically an adult size-wise and behavior-wise, with the [16] children, he might be admitted to an adult ward.

Q Is it possible, then, that there are some people who are less than eighteen years old, and voluntarily admitted pursuant to this statute that we're concerned about here . . .

A It could happen.

Q . . . they might be in the adult wards?

A In case of overflow, there is an urgent need to admit the child, we might transfer our oldest patient from the children's unit to sleep on an adult ward. We have just initiated this contingency plan, because when we reach the maximum bed occupancy. I don't think it has been implemented so far.

Q You say that—you've said that referrals come often from community mental health centers, is that right?

A That's right.

Q You also have people come directly to the hospital for purposes of admitting their children?

A Very few in the case of children. It's more adults.

Q Okay, so most of them come—are referred to you from the county centers.

A That's right.

Q If you could, just for purposes of clarification, could you just describe what would happen, let's say, in a typical situation where the parent wanted to admit his child pursuant to this statute, who lived, let's say, in one of the outlying counties that had a community mental health center?

A I can only speak in hypothetical situations.

Q Well, hypothetical—I mean, what would they do if they [17] wanted to admit the child and how would they go about doing it?

A They would have to bring the child to the mental health center and have mental health professionals review

the situation. By mental health professionals I mean a social worker or a psychologist, usually, who would then conduct a sort of pre-screening interview and assess the situation and determine whether the hospitalization is necessary. Then refer them to us. Where again, a screening process would take place.

Q So for sure if someone came to the hospital, to you directly—I realize that Ms. Kirkley went over some of this with you originally—if somebody came directly to the hospital to admit their child, would they be referred to the community mental health center? Is there any possibility that they might be—in a non-emergency situation, is there any possibility that the child . . .

A In a non-emergency situation, certainly they would be—they would be referred someplace else.

Q Okay. So the parent who has a child they would like to admit to the hospital would go to the community mental health center, and that child would then be seen by members of that staff. Do you know, for example in the community mental health centers, how many people they have—professional staff; psychiatrists, doctors, psychologists, social workers?

A None of the clinics in our hospital region of twenty-nine counties does have a full-time psychiatrist.

* * * * *

[19]

* * * * *

Q Okay. So let's just take our hypothetical where we are, then, let's say in one of the counties the parents come to the community mental health services there and say they want to admit the child. Let's just say they come in on Wednesday, March the 1st, or something like that. Then what would happen at that time, would an interview be set up for them to see anybody . . .

A If they bring the child with them, yes, somebody would interview the child as well as the parents.

Q At that time?

A At that time.

Q And then what would the next step be?

A The next step would be depending on the urgency of the situation.

Q Okay, let's say a non-emergency situation.

A In a non-emergency situation they would want to get some information from the school, if there has been—there have been any scrapes with the law, they would like to have some [20] information from the Sheriff's Office or some children—come into conflict with the law for drug possession and so on, so we want to get all the information collected then.

Q And—I don't know if I made the question clear enough. At the initial interview, would that be done by the social worker?

A Probably the social worker. It could be a psychologist, could be a nurse.

Q Okay, but it would be somebody at the facility?

A In the mental health profession, yes.

Q So you would have—you would have the initial interview and then there would be a search for secondary—information from secondary sources other than the child and the parents which brought in the child.

A The physician—the family physician could be a very important source of information.

Q So after . . .

A The pediatrician if they have one.

Q So after all this information was collected, what would happen then?

A That is presented to our adolescent unit.

Q Okay.

A Either by letter or phone, and then they schedule the evaluating interview at Columbus.

Q They would have the evaluating interview at Columbus?

A If the recommendation is to—for in-patient treatment.

Q And who would that recommendation be made by?

A By some professional in a referring agency.

Q And that professional could be a part-time psychiatrist or a [21] psychologist or the social worker?

A Could be, yes, yes.

Q So one of those people in the facility, in our case, makes a recommendation based on the interview with the child and information that was gathered from other sources?

A One agency is the Family and Children's Service.

Q They would go to them for information also?

A Yes.

Q And based on the interview and the information gathered from all of these secondary sources that you discussed, they say, well, we think the child should be institutionalized . . .

A Right.

Q Then they would contact the children and adolescent unit at your hospital . . .

A Yes.

Q . . . then an appointment or admitting—evaluation—I don't know if you used the term for interview, evaluation, a time would be set up . . .

A An intake interview or something.

Q And that would be conducted by somebody from your hospital . . .

A That's right.

Q . . . would go out to the . . .

A No, no, they would have to come to Columbus.

Q Okay. So this evaluation—it would be a recommendation that would be made at the community mental health center?

A That's right.

Q And to act on that recommendation, the involved parties would [22] have to go to the hospital . . .

A Of course, making a trip to Columbus and entering the grounds of the hospital does not constitute admission.

Q No, no, of course not. Of course not. So where we are now, we're at the gates of the hospital. We're not admitted, but we're at the gates. And who would come from the county, the community mental health center, would it be the . . .

A We request, when possible, the professional from the referring agency to be there. This is not possible in all cases. We, of course, accept written reports, recommendations, and so on.

Q Okay. So you have—there could be any number of situations, then, by the time the child is brought to the hospital?

A Yes.

Q The child would be there, right? The child would be brought to the hospital for purposes of determining . . .

A Usually, yes, unless the child is in some other institution.

Q Okay. Well, let's say the typical—in our hypothetical—is the child is in school, no other institution. Is it possible, then, that the admitting physician at your facility could make a decision after he has been informed of the case from the community mental health center, been told of that professional staff person's recommendation, has had sent to him the various items, you know, reports, copies of materials, school records, etcetera, has had those things sent to him, and then he will make—is it possible he will make a decision based on his phone contacts or letter contacts and the papers, without interviewing the child?

A No, not without interviewing the child. A tentative—tentative [23] agreement would take place, on the basis of the pre-admission information.

Q I see. So actually, there's like three—there could be three steps in this, like the recommendation, or the decision at the community mental health center, the recommendation on the admitting physician's basic feeling that there is grounds to have this child admitted—the pre-admission decision, and then finally, before the child is actually admitted, though, he would have separate interviews . . .

A Interview with the admitting physician.

Q And would the admitting physician speak personally to anyone else?

A Yes.

Q Who would that be?

A Whoever brings the patient; father, mother, guardian.

Q Is it the usual situation when the referral comes through the community mental health center, that the child is brought there by somebody from the community mental health center?

A No, it's usually the parents who bring the child.

Q Okay. And so . . .

A Those centers are under-staffed. They can't afford to send professionals to accompany the children.

Q Is that—is it possible that that under-staffing—I would assume, then, in light of your obvious efforts to make sure that no child is institutionalized incorrectly, and in light of what—the burden of their—really overburdened by their number of cases, and perhaps their under-staffing, lack [24] of people there, that the thoroughness required in getting all this information takes some time, and there are no hasty decisions made to admit a child?

A No. No.

Q Do you have any—I realize—if you can't answer this it's all right, but do you have any idea of the time that would elapse from, let's say, the day the parents would take the child into the community mental health

center for purposes of admitting him—voluntarily admitting him, and the time that the actual decision to admit is made by the admitting physician at your hospital?

A The unit director of the childrens unit would be better qualified to answer this question, but I would say that it may vary from the same day if it is—again, if it is an emergency, but we are not talking about emergencies . . .

Q No, just non-emergencies.

A Oh, it may take a week. It may take a week, by the time you get all the information pulled together. Depending also on beds. We may have no beds available, so . . . There is no hurry. They can assemble as much information as they can during this period of time.

Q Then it would be fair to say that the hospital, in a non-emergency situation, is in no great haste to put somebody in there?

A No, no, no.

Q Okay. I think I understand how it works on a dav to day basis.

A There is no motive to have them in.

Q No, I understand that.

[25]

A In fact, if there may be any dissatisfaction on the part of the community is that we do not have enough beds to give children, and in fact, our childrens unit was activated at the price of phasing out a medical-surgical unit, which had to be eliminated because the (intelligible).

Q When you were there prior to the institution of the

children and adolescent unit, where did children who would be voluntarily admitted under the statute—where would they go?

A No other place except Central State Hospital.

Q Would you make the decision at your facility, or would you just refer them to Central State?

A We simply didn't have any crises.

Q Okay.

A People didn't know that the hospital exists, and they were told that we do not have a children's unit.

Q It sounds like your hospital has a pretty close working relationship, out of necessity, with the community mental health centers, is that basically true?

A Yes.

Q Do you know if there . . .

A In fact, we share staff. Like I'm seeing patients . . .

Q That's right.

A . . . in the out-patient clinic.

Q Are there any policies set out—I know there are certainly admission policies which are in your Exhibits, but are there any policies, set out by the hospital, yourself, or the clinical director, in regards to the conduct at admissions at the mental health unit? Or do they have any policies as to what standards [26] and procedures they should follow? I can see you're not quite sure what I mean. Do they have any policies in regard to who should initially interview the child, the length of that interview, the subjects that should be covered, where that interview should take place, what secondary sources should be used,

if there should be any verification of information they get from secondary sources, things like that?

A I would say that they have such guidelines.

Q And are those guidlines written anywhere?

A I wouldn't be able to answer this with . . .

Q They aren't drawn up by you?

A No. No.

Q Okay. And . . .

A Up till now—up till now they really have been a separate systems in which the hospital has not had any input, but from the time of the consortium was created, there would be a closer relationship, in that the—each region—the superintendent of a regional hospital is also a chairman of the Mental Health and Mental Retardation Planning Consortium.

* * * * *

[28]

* * * * *

Q Just looking at, I guess it is Exhibit Two, which is a list of patients who have been evaluated and not admitted, and the patients who have been admitted, I notice that there are some referrals from the Department of Family and Children Services as well as the community mental health center. Is it the policy—do you know if it's the policy of the community mental—of D.F.C.S. first of all to refer cases to the community mental health center?

A This is the beaten pathway, because before the hospital was in [29] existence that's what they would do.

Q Okay, let me just ask you then, maybe to make it clear, on some of these where they are referred—I'm not concerned basically about any of this over here, but just

on the referrals, does this mean that these children who were referred to the hospital did not first of all go through the—like go through the community mental health center? Like on this one?

A That's possible, yes. But I think it really would be useful to have the people from the units to have answered these questions.

Q I understand. I don't expect you to be omniscient, you know. It is possible, though, according to Exhibit Three, that somebody could be referred from D.F.C.S. and not go through the intermediate step of being referred to the community mental health center?

A As a hypothetical question, I would say yes, because they may have already a very—very thoroughly researched background of the patient which had included prior contact with the clinic, and so on.

Q Okay.

NOTE: (Brief off the record.)

Q It would seem to me—I would assume, looking at the people—children who were admitted, that the standard diagnosis criteria is the D.S.M.-2?

A Yes.

Q And do you know generally—not just what's on the Exhibit Four, but just generally from the history of the children and adolescent unit, the number or percentage of children admitted pursuant to the voluntary admission statute with an initial diagnosis of perhaps one of the transient situational disturbances?

[30]

A Adjustment reaction of childhood?

Q Yes, something like that.

A Yes.

Q Do you know what percentage that would be of the . . .

A I am unable to answer that question.

Q Okay.

A We have not been operating that long to have any valid statistical data.

Q Okay. I guess for purposes, since we've been using the word emergency and non-emergency situation, I should get that straightened out, that when you talk about—what you said in your direct examination, that an emergency situation would be something that consisted of life threatening behavior?

A Yes.

Q And then a non-emergency situation is—generally—I don't want to put words in your mouth.

A Problems. Problems in getting along, learning—problems in learning and so on. This is the kind of problems that are referred to a psychiatrist.

Q And the decision to admit or not is based on the degree of disturbance or dangerous behavior to the family and the child's environment?

A Yes.

Q Okay. Based on that type of—what you've already testified to, is it fair to say that it could be that the interests of the child in this admission procedure, may be at odds with the interests of the parents?

A Interests of a child at odds with the interests of the parents?

[31]

Q Well . . .

A It may be at odds with the wishes of the parents as expressed by them at a given time, like in this case that I have mentioned.

Q Okay. Let me just ask you, in the one case you mentioned where the parents refused—for example where the parents refused to join treatment, you said the patient had previously been hospitalized in Central State?

A (Nods in the affirmative.)

Q I think you said that the unit basically felt, that after evaluation, that the mother was the more sick person of the family. Do you know if that patient was hospitalized at Central State under a voluntary admission? Do you know why that child was in Central State, I guess that's what I'm asking.

A I am not—I do not recall—the patient spent quite some time. I think that they, in Central State, the delay—the delay in the discharge, was due to the fact that the parents were not too keen to have the child back in the home.

Q But you don't know why the child was initially at Central State?

A I do not recall that.

Q But you did not admit the child . . .

A No

Q . . . to your institution? And I guess the child had gotten out of Central State because the parents had agreed to take it back—take her or him back?

A Yes.

[32]

Q Would you agree generally, that in the admission system, that it's important to get as much information as possible before the decision is made to to admit the child?

[32]

A Unqualified, yes.

Q And would you agree that the more facts available to the—I guess this is a corollary to the first assumption—that the more facts available to the physician the better he'll be able to make a reasonable diagnosis and . . .

A We do not operate a boardinghouse, where for a sum of money, somebody can get room, board and supervision.

Q Okay. How would you say the burden is on your physicians at the hospital? Do they have a heavy case load?

A Well, that depends on the point of view. There are hospitals that are much better staffed, private institutions, and there are hospitals that do not have half of the staff that we have.

Q I mean in regards to the, say—do the people that are involved with the children—the physicians who are involved with the children and adolescents, both in admitting and in treating, subsequent treatment of the children, do they also have to handle other type cases?

A The pediatrician also does provide medical coverage for the mental retardation unit.

Q What about the psychiatrist?

A The psychiatrist has other duties as well.

Q I'm sorry, could you repeat that?

A Has other duties as well.

Q So he—he or she, is handling both cases in the child and adolescent unit as well as some, perhaps, adult units.

A We would like to have a full-time psychiatrist—full-time child psychiatrist, of course.

Q Well, I mean—I'm not talking about just the characterization [33] of his ability, but I mean is the psychiatrist—who he cares for—so you have psychiatrists who are working with the children, but they are also having to work with the adults . . .

A Yes.

Q . . . because of time, money . . .

A That's right.

Q . . . limitations?

A That's right. But there is also a psychologist who spends most of his time there.

Q "There" is the hospital?

A The clinic—the child and adolescent unit.

Q Okay. So assuming then, there is a fair to heavy burden on your staff in the admission and treatment of children and other patients—would that be a fair assumption?

A That again, depends on the point of view that you look at this.

Q Okay. I won't try to make an assumption, then.

A If you think of ideal conditions, of course, it's different than when you think in terms of what is adequate, that's a different point of view. I would say we have adequate coverage.

Q Okay. Assuming that the more facts available to your staff and to the community mental health people, which I do believe you said are pretty over-burdened?

A Yes.

Q Assuming the more facts available to them the better—the better the treatment and the standards for admission, and assuming also that—like I said before, obvious in your Exhibits and in your testimony—the care in which facts are sought and the care in which you take to make sure that children [34] are not voluntarily—should say are not committed without . . .

A Good reason.

Q . . . then wouldn't a procedure which would consolidate some of the various steps taking place at different times and in different places presently, would such a procedure that would facilitate the gathering of all pertinent facts be helpful to the admitting physician at your hospital?

A I do not quite understand your question, what you mean by that.

Q Let me go over it then. You have gathered facts, both at the hospital—some at the hospital level by your use of psychiatric evaluations and interviews, of both, I imagine, parents, guardians and children—you also have gathered facts in the counties by apparently . . . D.F.C.S., and the gathering of those facts—those facts are gathered at different times and presented to the admitting physician at a subsequent time. What I'm trying to say, if there was a procedure which would facilitate the gathering of facts, help the overworked community mental health people in the gathering of facts, and allow an

opportunity for all the people who were involved in gathering those facts, to get together for the purpose of exchanging the information gathered, wouldn't that type of procedure be helpful in determining whether a child should be admitted to the hospital or not?

A What procedure do you mean exactly?

Q Well, it could be, let's say, all of these people getting together, and some person—not necessarily a Judge, because I don't want to engender some type of image, but an independent [35] person who would perhaps be able to be helpful in coalescing all that information together; all of this information being brought before a group and perhaps somebody there, an independent arbitrator, an arbiter there, to listen to this information and help consolidate that information gathered.

A You mean to duplicate—duplicate what we are doing?

Q No, no, not to duplicate it, but to make sure that all the information gathered is being done—just like your physicians' expertise are in psychiatry, no doubt about that, and the D.F.C.S. people, their information and the mental health people have certain expertise, but the idea is to get—to make sure that information which is gathered is utilized, and not wasted. That would be a goal . . .

A To make sure that the information is not wasted?

Q Well, certain people may have information that may be gathered by one source or another, may not be made known completely because of the way it's presented, or in the manner in which it's done. I mean, that does happen.

A I don't understand how could that happen. If you do get a report, . . . certainly read by the people who screen for admission.

Q Okay. But sometimes those reports, the way they're done, can sometimes be less than overall illuminating, isn't that true?

A Oh, I would consider all of them to be done in the problem oriented fashion, which facilitates the retrieval of information—of particular items of information that you are looking for at a given time. Might save some time, instead of reading the reports through to find a particular item of information [36] if you have a problem oriented system you can do it in a shorter time. But it's a matter of technique rather than a separate system of screening.

Q Okay. Then you don't feel that it would be helpful for all of the people who are involved in the decision—to get information and present it and—who are involved in the decision to admit, to get together at a particular time and . . .

A Well, I'll put it in this way, I don't think it would be helpful for someone else to do this job for us. I would certainly welcome to have more people on my staff, a child psychiatrist, a group of psychologists, social workers who could spend more time and more detail with all that, but a separate, duplicate system of screening, I don't think it would be necessary or good.

Q Okay. Well, we're both missing . . . each others assumptions. I'm not talking about duplicated procedures, but I guess that's a term of art that we both have relative definitions of that term, so let's just . . . . Do you feel that any type of other unit of getting together of all of the people who have information would be a duplication of procedure . . .

A Well, we do that. We do that, because we do invite social workers from the centers . . .

Q But they do not always come at the time . . .

A They do not always come. That's not always possible.

* * * * *

[42]

Q Okay, and the consultant comes once a week?

A In addition to that, yes.

Q And what would be the general purpose of those meetings?

A To get his opinion, a second opinion, an independent opinion of a person who is not an employee of the hospital, as to what we are doing.

Q And his opinion in regards to treatment, diagnoses, change in diagnoses, perhaps—whether a change of treatment should be—there should be a change in treatment or things like that, things of that nature?

A Well, a consultant—consultant's opinion is never a direct order.

Q Oh, sure.

A But certainly it is not—not countermanded usually. It's usually followed.

Q Okay. Then you mentioned that your own staff would handle the more routine matters. Could you just kind of explain what the more routine matters would be?

A I wouldn't say that they were routine. If there is—if among the staff, several—we have a team approach. If there is a difference of opinion between staff members as to the diagnosis or treatment, then of course, we need to have an umpire, and the evaluation of the input given by the consultant—an impartial consultant, helps to tip the

scales of opinion. And of course, by diagnosis I mean not a diagnostic label, which most people understand. Diagnosis in Greek means thorough understanding, and thorough understanding is certainly never a diagnostic label which can be put into two or three words, which [43] is a means of shorthand information—communication between professionals.

* * * * *

[47]

* * * * *

Q Okay. But just from the expression of your concern about—you do have some view points about the efficacy of the—of a legal system in regards to admissions, meaning you felt—I think you said you felt that the idea of a court getting involved in admissions was basically a reflection on the good will and trust and competency of your staff and I would assume that that's somewhat less than a recommendation for the use of the legal system or judicial system?

A I do not—I personally do not see the need because, as a physician, the guiding light for me is the Hippocratic oath, and in that—that encompasses the conduct.

Q Might it be helpful if the review team that you have, or your staff, including your child psychiatrist, if it contained someone who would basically represent the child's legal interest?

A Oh, yes, we have that. In our hospital we have instituted what is called Patient Advocacy Committee, which is not to replace, but is to supplement the function of the Patient Advocacy Unit, which is at the State level in Atlanta. And a member of the Patient Advocacy Unit is—one of the members is a lawyer from the Legal Aid Society.

Q Oh, that's Dan?

A Hay.

Q Hay.

A And he attends the monthly meetings of this committee and if [48] there is any question that the patients' rights may have been violated, this is investigated by this committee.

NOTE: (Brief colloquy.)

Q Are you pleased with the system as it works now?

A Yes.

Q Okay. Would you say it would have value to be instituted on a state-wide level?

A The Patient Advocacy?

Q Yes.

A Oh, I would think so. I would think so.

Q It hasn't caused any disruption, or problems with your review?

A No. No, it gives me, as the superintendent, another way of assuring that the patients' rights are not violated, and this committee is not—its main purpose is to put under a magnifying glass, any complaints that the patients have. The mandate for them is not to be objective, the mandate for them is to put it under a magnifying glass, in fact to be biased in favor of the patient.

Q And you see that as being—ultimately having good . . .

A Yes, because the inclination that I get there is complete, and there is no stone left unturned to indicate that something improper may have happened to the patient.

Q Now you don't consider that to intervene or to serve as a reflection on the competency of your staff?

A Oh, no.

Q Then would there be . . .

A It's a tool to improve procedures and policies.

* * * * *

[50]

* * * * *

Q Maybe I should put it this way. You said the average length of stay for adults about twenty-four days, and then Ms. Kirkley asked you what the average length of stay for a child was you said you honestly didn't quite know.

A We do have one, two, three children who were admitted in June.

Q Well, I'm talking about just averages. I'm not trying to pin you down on this, I'm just saying the average length of stay may be—may be twice as much as an adult?

A Yes. Oh, yes.

Q Okay. Then when Ms. Kirkley asked you why that was, you said the hospitalization of a child was much more serious a matter than that of an adult, is that right?

A Well, we—an adult can himself come and say I'm very sick, or I'm thinking of killing myself, or something like that.

[51]

Q Okay. When you're talking about adults are you talking about both voluntary and involuntary situations, or just voluntary situations?

A Both. Both.

Q But you realize that for an adult there is a court proceeding before he can be—there is a proceeding—court proceeding?

A Yes.

Q Okay. The last I have to ask you is, in your experience as a psychiatrist and based on studies you've done and your writings, would you say that hospitalization of any type can create obstacles for patients returning to the community?

A It can, yes, mainly to the stigma that still lingers among the population.

Q And there is a stigma attached to the . . .

A Unfortunately—it's unfortunate, but true.

Q And this stigma is—for psychiatric hospitalization is more severe than hospitalization for organic or physical . . .

A When people go to have their appendix out, they publish it on the radio, local radio, they have it printed in the newspaper, and yet they go to a psychiatric hospital, they don't do that, and in fact . . . it did happen, although there should not be any difference between the two.

Q But there does exist a difference . . .

A It does exist. It is the legacy of the past.

Q Which prevails in the present?

A Oh, yes. It still lingers. And of course, the more sophisticated, the more educated the population, the less this is evident.

Q I have no further question.

* * * * *

EXHIBIT 3

WEST CENTRAL GEORGIA REGIONAL HOSPITAL
CHILDREN & ADOLESCENTS UNIT
POLICIES AND PROCEDURES
SEPTEMBER 25, 1975

[1]

C & A UNIT POLICY ON REFERRALS FOR EVALUATION

Hospitalization for a child or adolescent will be considered only when it is therapeutically necessary or preferable over community outpatient care.

All referrals should be made through the local community mental health clinic or county public health department with a community-administered psychological evaluation recommending hospitalization. A child or adolescent will otherwise not be considered for admission unless in a case of emergency or where there is specific therapeutic justification for inpatient care.

A child or adolescent will be considered for admission by the Clinical Team of the C & A Unit in a screening-evaluation session which is to be scheduled by the Unit Social Worker. Where feasible the community worker referring the patient is requested to attend the screening-evaluation session with the patient; and where feasible, with the patient's parent(s)/guardian(s).

The community worker making the referral is requested to bring or send written information including any of the following available material: a psychosocial history, a developmental history and immunization record, a psychological evaluation, a psychiatric evaluation, a summary of previous treatment approaches, recommendations for treatment at time of admission, and any proposals regarding plans after discharge.

The decision on admission in the screening-evaluation session is based on the following criteria: The clinical assessment of the patient, treatment available by community resources, treatment offered in the C & A Regional

Hospital, and special mitigating circumstances indicating either inpatient or outpatient treatment.

When the screening-evaluation session results in a decision against admission to the C & A Unit the Clinical Team will recommend alternative community resources and make a referral to an appropriate agency. The C & A Unit Social Worker will inform the community agency of the referral and request follow-up.

[2]

CRITERIA FOR ADMISSION TO THE C & A UNIT

Patients with Intelligency Quotients or Social Quotients over 70 and who are less than 16 years, 6 months of age may be admitted to the C & A Unit.

An exception to this will be children under 16 years, 6 months of age and with Intelligence Quotients of Social Quotients below 70 who may be admitted to the Children & Adolescents Unit for evaluation and diagnostic tests, subject to prior approval from the office of the Superintendent.

[3]

WEST CENTRAL GEORGIA REGIONAL HOSPITAL
CHILDREN AND ADOLESCENTS UNIT
ADMISSION PROCEDURES

PURPOSE: To provide guidelines for the rapid and orderly processing of patients into the Children and Adolescents Unit.

1. Evaluation—A child or adolescent will be considered for admission by the Clinical Team of the C & A Unit in a screening-evaluation session which is to be scheduled by the Unit Social Worker. Where feasible the community worker referring the patient is requested to attend the screening-evaluation session with the patient; and where feasible, with the patient's parent(s)/guardian(s).

2. Physical & Mental Status Examination—Arrangements are made for a time when a physical and mental status examination can be performed by the physician. This is done on the Children & Adolescents Unit. At this time, the physician makes final preassessment and writes the order for admission.

3. Admissions Suite—The patient is then sent to the Admissions Suite, Medical-Surgical Building, with his or her parents or guardian for completion of necessary paperwork and photograph, lab work, and x-rays. At this time, his personal belongings are checked and list is made. Inappropriate items are sent home with the family.

/s/E. T. ZEITOUNI, M.D.
E. T. Zeitouni, M.D.
Acting Clinical Director

[8]

WEST CENTRAL GEORGIA REGIONAL HOSPITAL
CHILDREN AND ADOLESCENTS UNIT
EMERGENCY SCREENING PROCEDURES
(Evenings and Week-ends)

PURPOSE: To establish guidelines for admissions to the unit during evenings and weekends.

I. Procedure for handling calls requesting Emergency Services/placement:

A. Complete Emergency Screening forms, (located in the nursing station). Staff nurse on C & A will handle this.

B. Determine if child has been referred by a Mental Health Center, psychologist, or psychiatrist. If not, refer the caller to the Mental Health Center serving that geographic area (see attached list). If the referral is appropriate (child referred by Mental Health Center, etc.) be sure to complete all questions on the Emergency Screening Request Form.

C. After completing all items on the form, tell the person calling that the Social Worker will call and schedule an appointment the following morning for evaluation. This is only if the call is received Sunday to Thursday evenings. If the call is between Friday evening and Sunday noon, the person contacting WCGRH will be notified Monday morning by the Social Worker to schedule appointment.

D. If the contact person requests services more immediate than those provided above, supply the caller with the available and appropriate community referral service number.

E. Follow Up: Staff taking call and giving referral service numbers to contact should follow up with call to referral service.

F. All contact sheets (whether referred or appropriate contacts) are to be placed in Social Worker's office as soon as completed.

The Social Worker will make return call to contact the Mental Health Center or psychiatrist by 9:00 a.m. the following morning. An appointment will be scheduled as soon as possible.

[9]

Mental Health Center Emergency Referrals over Weekend:

If a Mental Health Center makes an emergency referral over the weekend when screening team members are not available:

A. Nurse in charge completes Emergency Screening Request Form, then contacts Unit Director, Social Worker, or Nurse Supervisor at home stating Mental Health Center's request for immediate placement.

B. Child is admitted according to clinical policy on admission procedure. Required papers completed. Physical and Mental Status done in Admission Suite.

C. Community Mental Health Center is contacted and requested to send, where feasible, a representative and parent or guardian to WCGRH Children & Adolescents Unit at 10:00 a.m. Monday morning.

D. At 10:00 a.m. Monday the Community Health Center representatives, parents/guardians, team members, and other involved agencies meet to discuss disposition. Other agencies were alerted to bring pertinent information on child to this meeting. Necessity of continued hospitalization is discussed at this time.

/s/E. T. ZEITOUNI, M.D.
E. T. Zeitouni, M.D.
Acting Clinical Director

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR JAMES B. CRAIG, taken on the 5th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, Atlanta Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
DAVID GOREN, ESQ.
STEVE GRANBERG, ESQ.
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For the Defendants: DOROTHY Y. KIRKLEY, ESQ.
Assistant Attorney General
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132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition, and he specifically waived that right.)

JAMES B. CRAIG, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A James B. Craig, M.D.

Q And where are you employed, Doctor Craig?

A Superintendent of Regional Hospital in Savannah.

Q And are you also a psychiatrist?

A Yes.

Q And are you board certified?

A Yes.

NOTE: (Defendant's Exhibits Numbers One through Seven were marked for identification.)

Q And would you identify Exhibit One please?

A That's my curriculum vitae.

Q Is that a current vitae?

A Yes, it is.

NOTE: (Brief colloquy.)

Q Now, Doctor Craig, what are your roles and duties as superintendent of the hospital?

[3]

A Well, basically to see that all of the patients are admitted and evaluated and treated and also to arrange for treatment after they leave the hospital through the community mental health clinics.

Q How many counities does the Savannah hospital serve?

A Twenty-four southeast counties.

Q And you also have community mental health clinics within that area?

A Yes.

Q How many of those are there?

A There's four catchment areas, and then we have some satellite clinics in addition to those.

Q And through those clinics are the entire twenty-four counties served in the community?

A They are.

Q What, in general, is the relationship between community programs in your area and the hospital?

A Well, actually, we have four non-medical unit directors, and these people are, say, unit directors at our hospital, and they also double as director of the community mental health clinic, and they visit the hospital at least one day a week and coordinate the activities between the hospital and clinics.

Q All right.

A They usually bring some other people with them, not just the unit director.

Q Do the community programs work with the hospital in the admission process?

A Yes, many of the patients come directly from the community [4] centers to the hospitals. Some of them are by-passed, and eventually you are trying to work toward all of your patients coming through the community cen-

ter before they come to the hospital. There will be rare exceptions no matter how good a system you get, but that's the ultimate goal.

Q Basically in this case we're talking about the voluntary admissions of children and adolescents, and then we make a distinction at times between emergency and non-emergency admissions. What would be, in the great majority of cases, the procedure for admission of a child on application of his parent to the hospital?

A Well, usually they would—occasionally, say, a parent would make application directly to the hospital, but usually they would go through the clinic, or through some other agency.

Q Is this written, as a policy of the hospital?

A Yes, and I think you have a copy of that.

Q Is that Exhibit Two?

A Yes, uh-huh.

Q Okay. Could you just summarize that?

A Well, it actually lists, say, the people who do refer patients and—parents, foster parents, individuals occasionally, D.F.C.S., juvenile courts, vocational-rehab, and then the case is evaluated, say, before he's actually admitted, and many times they are not admitted, they are just evaluated and then other referrals made to adequate treatment facilities—programs.

Q This evaluation you're talking about, would it occur first at the community mental health clinic?

[5]

A If it was a referral from there, yes, uh-huh.

Q And do you know what kind of evaluation this is and who performs it?

A Not specifically, but each catchment area has a person who is a coordinator of the child and adolescent . . . , each one of the four catchment areas.

Q If a child—if a parent presented a child directly to the hospital without any evidence that the child had been through a community program, and the receiving person at the hospital determined that it was a non-emergency situation, would the parent be referred back to the community mental health clinic?

A Definitely so.

Q So your admissions directly to the hospital would be in emergency situations?

A Yes, if it was a direct admission without going through any other agency. It would definitely have to be an emergency.

Q And what are the criteria, in your opinion, of an emergency admission?

A Well, I'll give you an example of one just recently, and I think it was a pretty good example, of a child who had been placed in a group home, and the child became extremely upset, got a butcher knife and threatened one of the house parents and threatened to kill himself, and he was put in jail that night. The next morning several people called us about taking him in the hospital just for an evaluation to see if he was too sick to be in that home, that he needed to be in a different kind of home, and it was just for a respite kind of thing, really. And arrangements are already being made—he's been there [6] approximately one week, and arrangements are being made now to send him to a different group home.

Q Uh-huh.

A And working with the say, people involved in the new home before he's actually sent there, meaning they'll come to the hospital, our people will go out to the home.

Q Basically would an emergency admission involve a situation where a child was dangerous?

A Frequently, and I think occasionally it would be when they had just run away, say, from a group home, their own home, and rather than put them in jail, put them in the hospital as a respite for evaluation.

Q And then an evaluation would be conducted right there . . .

A It would start immediately, yes, uh-huh

Q And a decision would be made within a week, say?

A Yes, I'm sure it would be a week or less. Occasionally it takes two or three weeks for a complete evaluation.

Q I know this is a general question, but looking at non-emergency voluntary admissions, what criteria does the admitting physician look for in deciding to hospitalize a child?

A I think basically that he is convinced that, say, by the fact that he has been tried in other situations and not made it, or maybe, quote, "too sick to even try right then," meaning like if a person was an acute schizophrenic, I think it would be the wrong thing to send him back to a mental health clinic . . .

Q Okay. Would you identify Exhibit Three, please?

A These are the dates and initials of people who were evaluated and were not admitted in 1974—fiscal year '74, '75.

[7]

Q Do you have any policies, Doctor, with regard to treating families and children at the same time that they're admitted to the hospital?

A When a family is available, all efforts are made to get them involved in the treatment. Not only in the treatment, but in the original evaluation.

Q Would they be involved in treatment at a community program or at the hospital itself?

A Either or both.

Q Are you aware of any general reluctance on the part of parents to participate in the treatment program?

A Oh, sometimes, yes.

Q From your experience, do you have any estimate of what percentage of parents are reluctant to participate in the treatment?

A Oh, it would be a pure guess, actually. I'd say if the parents are available and are approached, say, the right way, and sometimes repeatedly, I'd say there would be less than twenty-five percent that wouldn't participate, but again that's just a guess.

Q Can you think of any specific instances?

A No, because I'm personally not directly involved with the child and adolescent program.

Q Okay. What is the physical plan of your child and adolescent program?

A We have forty beds, and it's divided up into, more or less, four sections; the building and including, say, dayrooms and also classrooms.

Q And how many beds?

[8]

A Forty beds altogether.

Q Are the children and the adolescents separated?

A No. Well, I—within the building, not a separate building.

Q But within the building there's a separate place for children and a separate place for the adolescents?

A That's right, uh-huh.

Q And . . .

A But they do get together at certain times of the day . . .

Q Who is the . . .

A Eating time, and school time, etcetera.

Q Who is the physician that's basically in charge . . .

A Doctor Spirioza.

Q Is that a woman or a man?

A Man.

Q Is he a psychiatrist?

A Yes, he is.

Q Would you identify Exhibits Four and Five, please, Doctor?

A Number Four is the linkage of the child and adolescent unit to the community programs. Number Five, staffing procedure for the patients in the child and adolescent unit.

Q Do you have a plan at the hospital, Doctor, for periodic review of in-patients?

A Yes, all of them are, quote, "Staffed originally," meaning, say, not only people involved in the evaluation but also people from the outside and also referring agencies, and this usually occurs within the first three weeks, and after that, once a week. I think it's on Monday. All of the staff get together first thing [9] Monday morning and go over all of the patients and up-date their plans and progress, etcetera.

Q The first meeting within three weeks, you said involves some community . . .

A That's right.

Q . . . people as well . . .

A Uh-huh. (Affirmative.)

Q Do the weekly meetings?

A No. They are invited in when plans are beginning to crystallize for the people to be moved out, and actually, I think in this particular unit, I can't say for sure, it is in the M.R. unit, for sure, when a big staffing is made, there is a list of people that the notifications are made, when the staff is going to be, and who it's going to be on.

Q Uh-huh. Do you have any kind of utilization review where cases are reviewed by persons other than the staff of the C&A unit?

A Yes. A nurse—one of the nurse supervisors is head of this committee, Ms. Jean Cleland.

Q And how often does she review cases?

A It depends on diagnosis. You know, they set out certain standards for if you've got this kind of condition

they have to be reviewed every two weeks, and others every three weeks, etcetera.

Q And who sets those standards?

A Oh, basically, I think it comes from A.M.A., and also . . .

MR. TARUTIS: A.M.A.?

A A.M.A., the American Medical Association. I'm not exactly sure on that, now, but they have a lot to do with it and also the [10] Georgia Psychiatric Association.

Q Would . . .

A And Medicare-Medicaid dictates certain ones that we'll review ever so often, too, don't leave that out.

Q Would all the children in the unit be reviewed periodically?

A Yes, by that committee.

Q By the committee?

A Uh-huh, (Affirmative.) in addition to the review ever week.

Q Is there a set period when each case will be reviewed, or is it . . .

A A set diagnostic category.

Q By category?

A That's right, uh-huh.

Q And do you have any idea what the set period is for schizophrenics?

A No, not right off hand, but I would say probably once a month.

Q What about behavior disorders and transitional . . .

A I wouldn't want to venture to say because we have a list that goes with this . . .

Q Uh-huh.

A . . . the survey and they know which ones to do.

Q Did you bring that list with you?

A No.

Q Doctor, would you identify Exhibit Number Six?

A This is a listing of all the cases by number that have been admitted to the hospital since it was opened in 1970.

Q Who prepared that?

A Medical records library.

[11]

Q Did they have to prepare it manually? That's what it looks like.

A They had the print-out and they had to fill in this manually. They had to review each record to complete these items over here. . . .

Q Uh-huh.

A Because you know, after so many years you store records in a different place than your current records.

Q Now would you identify Exhibit Seven for us, please?

A It's a summary of the information I just referred to.

Q And who prepared the summary?

A The same people in medical records.

Q Did you ask them to prepare it for you.

A Yes, I did. I asked them through Mac Daily (phonetic), who is my administrative assistant.

Q Are you aware, from your experience, Doctor, of any general reluctance of parents to take their children out of the hospital after your staff recommends discharge?

A Yes, you always have a few of these, because with the kinds of, say, cases you get admitted to a hospital, meaning that many times it's because of their disinterest and inability to get along that the child gets sick.

Q What percent of your cases would you guess . . .

A That what?

Q . . . that parents are reluctant to take their children home, do you have any idea?

A I'd guess five to ten percent, but the reason I was hesitating, is on the other side of the coin, some of them want to take them home and they shouldn't.

[12]

Q Uh-huh. What steps do you take if parents are reluctant to take their children home?

A Well, I think first by—if we think, say, it's to the best interest of the child we try to work with those parents, either at the hospital, or through their connections with community mental health centers, because if you make them take them home, you're doing a disservice to the child.

Q Doctor, one of the issues in this case, and one of the contentions that the plaintiffs are making, is that there is a necessity for judicial proceedings prior to the admission of each child to the hospital on the application of his parents. In your opinion, as superintendent and as a psychiatrist, would such proceedings be necessary?

A I don't see where it would be helpful, personally. I think the most important thing is what you do for the

child after he gets there, not how he got there, and basically—well, for at least twenty years, psychiatrists in generally have been fighting to, say, get rid of the court procedures having to do with mental illness, children as well as adults, and treat it as any other kind of illness. And in the State of Georgia, this was first accomplished, really, to my recollection, 1960, when the 1960 Mental Health Act was passed.

Q Is it your opinion that the procedures that you've established for admissions and for screening are adequate to make sure that children are appropriately hospitalized?

A I feel so. Definitely so.

Q At this point in time, is it a policy to treat the children at home whenever that's possible in your medical . . .

[13]

A Oh, definitely so, yes.

Q That's all the questions I have.

A Not only with children, but adults, too.

NOTE: (Brief off the record.)

NOTE: (Defendant's Exhibit Number Eight was marked for purposes of identification.)

Q Going back on direct, Doctor, would you just identify Exhibit Number Eight?

A Eight is a copy of all of the admission papers on the present population of the C&A unit in Savannah, plus a copy of social service history, plus the physician's admission note.

EXAMINATION BY MR. GRANBERG:

Q Let me just ask you Doctor, what's the number of physicians you have at your institution?

A Twelve and a half.

Q Twelve and a half?

A Yes. We have some part time physicians.

Q Okay.

NOTE: (Brief colloquy.)

Q And of the ones that are there full time—well, I guess the ones—anybody who has—is the half time person not a consultant, but he works for the . . .

A On a part-time basis.

Q . . . but he works for the hospital.

A Uh-huh. (Affirmative.)

Q What kind of doctors do you have?

A Well, actually we have pediatricians, internist, one psychiatrist, [14] and another general practitioner, who are part-time.

Q And of all the physicians there, there are twelve, then, twelve full-time and three part-time?

A It amounts to twelve and a half. Some of them are four-fifths and this kind of thing.

NOTE: (Brief off the record.)

Q How many psychiatrists do you have there?

A Eight.

Q And how many of them are certified, board certified?

A One.

Q The others are board eligible?

A All but one.

Q Do you have any child psychiatrists?

A No, not a person who has completed their training in child psychiatry, no.

Q Okay, do you have anybody that is in the process of it? Just in the way you answered that question, I got the impression . . .

A No. See, to be a child psychiatrist you have to have, say, so much general psychiatry, formal training, plus two years of child psychiatry, and we don't have any such person.

Q You don't have anybody who is going through the training, or anything?

A No.

Q Okay. Do you have any foreign born or foreign trained physicians in your institution?

A Yes, we do.

Q Do you know how many?

A Eight.

* * * * *

[17]

* * * * *

Q When was the screening policy of children adolescents unit promulgated, is that the correct date, November 17th, 1975?

A This is when it was written, yes. It was in effect before then, but it was not written.

Q When was it originally in effect, I mean, when did it go into effect?

A I was told shortly after the inception or opening of the unit in 1970. I can't clarify that because I wasn't there.

Q But it wasn't written until November 17th, 1975?

A Not in the present form. They had some set procedures in the nursing manual, some in the general hospital manual, etcetera, but it never was gotten together like this.

Q In regards to Exhibit Five, which is your staffing procedure concerned with which people are going to get involved with review after admission, do you have any kind of—I can see from here it's a wide-ranging assortment of people who said—the memo said could be involved or invited. Do you have anything like that prior to admission, either formal or informal policy?

A Not that I know of in written form.

[18]

Q Well, just in unwritten . . .

A I think if you'll go back to that other one, you have something in that, as far as November of '75—as far as the screening and who participates and who is contacted, etcetera.

Q Okay, but I think—let's see, are there anybody involved—that certainly provides for people outside of the institution to get involved, but . . . wide range of people to get involved, is there anything provided for formally or informally at—prior to admission?

A Not other than what's written, no.

Q Do you think that could be beneficial, do have that wide range . . .

A I think it might. I think it might be an improvement. Can I look at this for a minute?

Q Surely. I guess you'd agree with the fact, just from looking at your policy here and your concern not to admit people unless necessary, especially children, that the more

facts available to the admitting physician, then the better he's able to make a reasonable diagnosis and the better he is to make a decision as—in regards to admission?

A I think that's always true, if it's available at all. I think every effort ought to be made to contact people other than, say, their immediate family, too, and I'm sure it has been done, even though it might not be written down.

Q Can you just briefly describe, and it doesn't have to be very long, just exactly what would happen in the usual situation if somebody out in Waycross or some of the other outside counties [19] wanted to admit his child in a non-emergency situation to your hospital?

A Well, I can just—by citing a case two or three months ago. This mother called me, and I don't know whether her physician or somebody that she was . . . had advised her to admit her child, which it seems to me it was a seven or eight year old girl to the hospital, and my first question was, "Well, who recommended that she be admitted and why?" And she told me who it was, so then my next question went, "Well, has she really had any evaluation on the outside other than this person that you are quoting?" And she said, "No." And she was referred to the—this was the Waycross clinic, and I don't think we ever got the child.

Q So that child would be referred to the community health . . .

A That's right, and they would either treat him or make other arrangements for his treatment, or her treatment.

Q The other arrangements—if the arrangements included institutionalization, would they make the decision

at that point or just make a recommendation to you, to your hospital, that he be admitted?

A You mean the clinic?

Q Yes.

A They would recommend and send us the material —written material if they had time, or communicate by telephone through their child and adolescent worker, and each one of them has one designated.

Q And then the child would be brought to the institution—if they recommended that the child be brought to the institution [20] there would be another . . .

A Evaluation there.

Q . . . would there be a separate . . .

A That's right.

Q Would there be a psychiatric examination at that time?

A Yes, before the child was formerly admitted.

Q There is no psychiatric examination at the clinic level?

A Sometimes it is. Most of your clinics have—well, all of them have at least a part-time psychiatrist.

Q I see.

A Savannah has one full-time and about four part-time.

Q Do you have any type of policies in regards to the conduct of the interview or the—at the community mental health level?

A No.

Q Or any type of policies that you would dictate to the clinic in regards to what facts are to be assembled?

A I think they would be told by whoever—asked by whoever they contacted at the hospital if they had such and such information and be sure to send it ahead or bring it with the patient when he comes for an evaluation.

Q And do you have any policies in regards to the conduct of the psychiatric interview of the child or of the parent at the time—at the hospital?

A No, not any specific policy, and that would depend so much on, say, the situation, the background and philosophy, say of the individual psychiatrist who was doing it.

Q Are you familiar with any studies that have been done—conducted in regards to the method of conducting psychiatric [21] interviews with children?

A Not any recent studies. Of course . . .

Q That's not meant to put you on the spot, but try to draw one out if you can . . .

A No, I haven't been especially interested in child psychiatry for some time, even though I did it for awhile.

Q Do you know of any statewide policy in regards to—promulgated by D.H.R.—Division of Mental Health —in regards to admission procedure?

A You mean that would be put out through Doctor Philley's department?

Q Well, I don't . . .

A He's head of child and adolescent . . .

Q Anybody from the D.H.R., Division of Mental Health?

A Yes, I'm acquainted with some general memos that were sent around on this, but I couldn't tell you the content of them.

Q Do you remember when they were sent around and by whom?

A That would be probably Doctor Philley.

Q Do you remember approximately when they might have been?

A Well, it would have to be in the past year, because he hasn't been here much longer than that.

Q How many children are in the Savannah hospital now under the voluntary admission?

A I'd have to go through the papers.

Q You don't know off the top of your hat?

A No there are twenty-nine there altogether.

Q Okay. And do you know what the average lengt of stay would be for a voluntarily admitted child?

[22]

A I think you could just give the general average length of stay, because I've never seen it broken down as far as the type of admission. The average length of stay is between five and six weeks.

Q And do you know with regards to those children admitted, how many had a diagnosis at admission of some type of transient situational disturbance?

A No, I'd have to look at the summary of that.

Q I'd assume at the time of admission, the criteria for diagnosis is the D.S.M.-2?

A I'd have to see the form to answer that.

Q You don't have any standard . . .

A You mean—you mean actually the . . .

Q For making the . . .

A . . . nomenclature book?

Q Yes.

A It's called the gold book now. Yes, it's gold colored this year.

Q Okay.

A It was gray before.

Q So it is the D.S.M.-2?

A That's right. There's another one on the way out, too.

Q Have you ever had any contact with the Legal Services attorneys down in Savannah, any of the Legal Services attorneys, you or any members of your staff?

A I'm sure our staff has, yes.

Q Do you know if any of them play any role in regards to policy advisement—not policy, child advocacy units or anything [23] like that for periodic review?

A I don't know.

Q Under—according to Exhibit Five, you have quite a few people from the outside coming in to help you initially to evaluate a child's case, and determine, I guess—I would assume, and I'm not saying this specifically, to determine what the type—what type of problem it is and perhaps what alternatives are available for treatment outside of the . . .

A Yes, basically that's the reason for them to come in, including the judges, frequently. Juvenile Court Judges.

Q Oh, they are there?

A Frequently, not always.

Q Do these people who are invited to come usually come as a practical matter?

A Quite a few of them do, yes.

Q Who are the ones that come the most?

A I'd say the people from, say, the community clinics.

Q And this—would this hold true for the ones—the—for the community mental health clinics out in, let's say, the counties, further out in the counties?

A Yes, they come from Waycross frequently. That's a hundred and ten miles.

Q Do you think it would hurt you if you had another person there at these meetings to serve as a advocate for the child in regards to his legal rights?

A I think it would depend on who the person was and how they conducted themselves.

Q Certainly. I meant—I should have said as a given—it's [24] not—the purpose is not to disrupt the proceedings . . .

A No, if it was for the purpose of helping, I don't think we would have any objections. I think at times it would help.

Q All right. Do you think that state-wide the other—the other hospitals should have a program like this which involves outside persons like the ones we just talked about on a regular basis?

A I'd be biased, but I don't think we need it.

Q You don't think what?

A I don't think it's needed.

Q Oh. You go the extra step?

A Yes, I think so, because we make every effort to get the child out.

Q These people that come in—I want to make sure I've got this right chronologically. They come in within three weeks of the admission date . . .

A Uh-huh. (Affirmative.)

Q . . . and then they're invited in again . . .

A When some change is indicated by the weekly meeting that the staff has.

Q A change in regards to what?

A Plans in treatment, disposition. Meaning as a child goes along, you can't always predict what he's going to need, say, a month from now.

Q Could it be just a plan—change in treatment at the facility . . .

A Well, if it was that it wouldn't be as necessary for them to [25] come in as it would be in a planning for future treatment outside.

Q Okay. Basically, then, these people are invited in when you're talking changes as to a different modality . . .

A That's right.

Q . . . outside of the hospital . . .

A Not just every change in the hospital.

Q It's usually a change . . .

A But we don't object to them knowing that, and if they do come, fine.

Q Just one question about the utilization review com-

mittee. How often are the children and adolescent cases reviewed?

A I think . . .

Q Is that the thing that's based on the diagnostic categories?

A That's right.

Q Okay.

A That was all set down by . . .

Q Okay. The example you gave of a child who had been involved in a potential knifing, or an attempted knifing, you said he was there a week and . . .

A Well, he's still there. He's been there a week, and they staffed him yesterday with the community people from Brunswick, and plans are already being evolved where he will go to another group home in that area, but not the same home.

Q Do you know which group home that is?

A The one he's going to?

Q Yes.

A It's the one in downtown Brunswick.

[26]

Q Okay. Now, what particular relationship do you have with foster homes and group homes there? It seems, from looking at your—that summary sheet, that you do place a lot of children in group home settings?

A Actually, our people usually do not do the actual placement. It would be D.F.C.S.'s policy, supportive home—supportive living program . . . foster homes.

Q How does D.F.C.S. get involved? Do they come to these staff meetings?

A Yes, they frequently do, and they sometimes have custody of the child.

Q And would they base that on your recommendations—should say—they might have custody of the child before he's admitted, or are you talking about situations where you'll make a recommendation that they bring an action to terminate parental relations?

A No, the latter would be rare. The former is usually the case, where they actually already have custody.

Q Okay, even considering the situation you have there, I imagine there are times though, when the—perhaps the doctors determine that a child no longer needs hospitalization, yet the child is not released to an alternative outside the hospital or at least drastic—less drastic environment because there are no other alternatives available outside of the hospital?

A I think one of the things needed in this state along these lines is group homes specifically for adolescents. As far as I know we don't have any. (To Ms. Kirkley) Do you know of any? [27] The department is working on this now.

Q The Department of Human Resources?

A Well, the Division of Mental Health. I can't speak for the department. But I think you have to pursue more than one avenue to try to get people out.

Q Surely. One thing you said about judicial proceedings, was that the most important thing, the thing—what you do when the child gets there, when he gets to the hospital, not how he gets there.

A Uh-huh. (Affirmative.)

Q Okay. Do you have—is there some concern, though, that if it's important that the child shouldn't be there to begin with, to make sure that he isn't admitted?

A I think if he really shouldn't be there at all we don't admit him.

Q Okay.

A Meaning this group in this Exhibit. (Indicating Exhibit Three.)

Q Oh. Do you think judicial attitudes in regards to mental health laws have changed in the last twenty years or so?

A Whose attitudes, now?

Q Judicial attitudes.

A Yes, according to the literature they have.

Q Okay. As a matter of practice?

A Yeah, I think all the, quote, "rights of patients" we read about, and I think try to conform to, and I think do, but as far as judicial commitment, if I might say so, I think is a step in the wrong direction.

[28]

Q Okay. Because . . .

A Meaning I went through this for twenty years.

Q Okay, are you saying because your procedures are adequate?

A Yeah, uh-hum, in the safeguards of the patients, I think I have . . .

Q All these procedures that you've institutionalized, procedures for . . . safeguards and policies that you've shown us in the various exhibits here, those were all implemented by you or your predecessors, or . . .

A Yes, by me or my predecessors.

Q Okay. But they aren't incorporated as a matter of state law or regulation, are they?

A Not that I know of.

Q So they—these policies are subject to change, or could be changed in the future?

A Yes.

NOTE: (Brief colloquy.)

Q What is the average case load of each physician at your institution?

A Oh, it varies within the units, really.

Q All right, let's start at children and adolescents, then.

A Well, the capacity is forty, and it never runs forty.

Q Does he have any other cases that—is he responsible for any other cases other than those in the children and adolescent unit?

A Not in the past six months.

Q So he's concerned solely with the . . .

A Well, I'll elaborate on that a little. Prior to six months ago [29] he had to take, quote, "his regular rotation in the alcohol unit" because of the big load. That was discontinued. Up until, say, approximately one month ago he had the medical responsibility for approximately thirty-five other cases in M.R., but not as far as running the M.R. unit. Now he does not have that.

Q So what he's got—his only cases are those in the C&A unit?

A That's right.

Q What about the other doctors, do you have any idea what their average case load might be?

A Oh, let's see. The Brunswick unit, it varies a little from unit to unit, but it wouldn't be more than forty; probably thirty or thirty-five. And the Medical Infirmary would be ten. Chatham-Effingham would average about thirty-five. Alcohol would average around fifty.

Q What—in your role as the chief administrative officer of the hospital, the superintendent, what do you think would be, like, the ideal number of cases per physician?

A I don't think our physicians are over-loaded.

Q Okay.

A Maybe because I've worked at other places where they had so much more to do.

Q Did you say, like, in the children and adolescent unit, that—what he's doing, the capacity—there were . . .

A Forty.

Q . . . forty, that would be suitable?

A I think so, along with, say, the other professional people that he has, psychologists and social workers, school teachers, [30] etcetera.

Q Are children admitted pursuant to the voluntary admission statute, are they ever admitted due to problems involving the entire family?

A Oh, I think you could talk about that a long time. I think . . .

Q Well, let me just phrase it another way, then. Is it—listening to your testimony on direct, do family problems often result in the parents trying to voluntarily admit the child?

A If I had to answer that a yes or no, I'd say no; but I think it needs a qualified answer.

Q Okay, please qualify it.

A Meaning that I think everybody realizes that children frequently become emotionally upset because their parents are not getting along good together. I think frequently as we say, the family is sick along with the child. If you take this into consideration, the answer would be yes sometimes, yes.

Q Okay. In regard, then, to . . . could you say—would it be fair to say that the interest of the child—the child may be—his parents are trying to voluntarily admit him pursuant to the statute—the interests of the child are sometimes at odds with the interests of the parents?

A You mean that it's not primarily for the good of the child, the necessity of the child being admitted?

Q Well, that's one aspect of it.

A Uh-huh. I'd say no, I think we would detect this, say on screening, really.

Q Okay.

A I think what you're getting at is they're just dumping the child [31] to get the child out of the way.

Q Well—okay, I assume that—those kind of situations can happen, that it's possible to stop those situations, to catch them, but I'm not trying—I'm not saying—I'm not talking categorically that's not—that's the only thing. I'm just saying that there is a potential—is it true that there could be a potential conflict of interest between parent and child in these types of situations?

A I think so, but I still think we would be likely to catch it on screening.

Q I have no further questions.

END OF DEPOSITION

* * * * *

EXHIBIT 2

#225-23
[1] 17 November 1975

GEORGIA REGIONAL HOSPITAL AT SAVANNAH
CHILDREN AND ADOLESCENTS UNIT
SCREENING POLICY OF CHILDREN AND
ADOLESCENTS UNIT

Purpose: to delineate screening procedure for admission to Children and Adolescents Unit

The Children and Adolescents Psychiatric Unit of the Georgia Regional Hospital at Savannah has a capacity of 40 beds. The unit provides in hospital psychiatric services to children and adolescents between the ages of three years and 16 years, six months with mental, emotional, and behavioral disorders not amenable to being served by any existing outpatient facility. Patients admitted to this unit should not have a physical condition beyond the capability of the Medical-Surgical Unit to handle, nor have an intellectual ability permanently below the mild mental retardation level.

Applications for admissions and referrals are accepted from other hospitals, mental health agencies, institutions, juvenile courts, educational and correction institutions, vocational schools, children's homes, group homes, professionals such as psychologists and physicians, parents, foster parents, and in special cases, the individual youngster.

The unit is directly accessible to the public by telephone, mail, and actual walk-in. The admissions screening group is a part of the unit team: the psychiatrist, two social workers, a psychologist, and the nurse in charge of the unit.

Craig Defendant's Exhibit Number Two
JMW 12/5/75

The two social workers on the unit receive all inquiries, referrals, and applications directly during regular working hours; after duty hours the nurse in charge will receive such inquiries through the hospital Admissions Office.

Each inquiry is immediately handled. Information and appropriate help is provided at the first contact, especially if another agency appears to be more suitable to meet the needs of the requesting party.

A screening journal is maintained on the unit. Each inquiry or referral is entered by means of a short note by the screening staff listing: names, telephone numbers, and addresses of the inquiring person and of the prospective patient. Also included are essentials of the particular case and the action taken to assist the inquiring party.

Referrals with recommendations for admission, for purposes of a psychiatric workup and/or treatment, coming from a court, a hospital, a physician, or a Comprehensive Mental Health Clinic are accepted without delay. The requesting party is instructed about the legal requirements that a patient who is a minor must be accompanied by a parent or legal guardian at time of admission for purposes of signing application, admission documents, and providing anamnestic data.

Requests for admission not signed by a physician are subject to a more complex screening procedure starting with immediate measures taken by the social worker to research and complete every possible pertinent information about the case, [2] previous psychiatric treatments and recommendations, follow-up, and within 24 hours the case is presented to the psychiatrist with every effort to have a pre-admission interview with the patient and accompanying person included in the screening process. The

SCREENING POLICY OF CHILDREN
AND ADOLESCENTS UNIT #225-23
Page Two 17 November 1975

decision for admission is given by the psychiatrist after deliberation with the involved social worker, nurse in charge, and psychologist.

The requesting party is instructed to proceed with the admission by presenting themselves to the Admission Suite of GRH/S. The Admission Suite is immediately notified by the social worker or by any other member of the unit's screening group about the decision to admit this patient.

If the admission is denied by the screening group or refused by the patient or accompanying parents or by the custodian, appropriate advice is given by the involved screening staff regarding alternatives to hospitalization and practical measures offered to establish the first contact of the patient with the alternative agency. A final note in the screening journal is written by the staff with clear description of the situation at this stage of the screening, and the case is temporarily closed.

The screening journal is a confidential part of medical records, kept on the unit under the custody of the social worker in chief during two calendar years. At the beginning of the third year, the screening journal is properly destroyed.

In seven to 21 days from the date of temporary closing of any case not admitted, an attempt is made by the responsible social worker to contact the patient, parents or custodian, or referring agency and offer additional help if necessary.

/s/ J. B. Craig, M.D.
Superintendent

/bs
Dist. All MED Units

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR EVERETT C. KUGLAR, taken on the 5th day of December, 1975, in Room 534 of the Georgia Department of Health Building, 47 Trinity Avenue, S.W., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

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APPEARANCES:

For the Plaintiffs: GERALD R. TARUTIS, ESQ.
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[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition and he specifically waived that right.)

EVERETT C. KUGLAR, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MS. KIRKLEY:

NOTE: (Defendant's Exhibits Numbers One through Four were marked for purpose of identification.)

Q Would you state your full name for the record, please?

A Everett Clark Kuglar.

Q And you are a medical doctor?

A Yes.

Q Are you a psychiatrist?

A Yes.

Q Are you a board certified psychiatrist?

A Yes.

Q Would you identify Exhibit One, please?

A Yes. This is a brief biographical sketch.

Q Is that current?

A Yes, with the exception of the fact that I am now Lieutenant Colonel of the Medical Corp of the U.S. Army Reserve, instead of Major, it's current.

[3]

NOTE: (Brief colloquy.)

Q And where are you employed, Doctor Kuglar?

A Georgia Regional Hospital at Augusta.

Q And what's your position there?

A I am the superintendent.

Q How long have you been the superintendent?

A Since 1969.

Q When was that hospital opened?

A In 1969. I essentially came on board about the time the hospital opened.

Q All right. What are your roles and duties as superintendent of the hospital?

A The roles and duties are the direction of all programs at the Georgia Regional Hospital at Augusta, and also those mental health programs for which the hospital and the division in the department, contracts with local health departments in our area.

Q How many counties are in the area?

A Thirteen counties.

Q And how many community mental health clinics are there?

A There is one complex of community mental health clinics located at the Augusta area. This means more than one center site. We also have—of the twelve remaining counties that we serve, we have a satellite-type program in ten of those twelve counties.

Q But the community program is centered in Augusta?

A Yes, with satellites in the small—the way we are geograph-[4]ically located . . . catchment area of three hundred and twenty-five thousand. Approximately two hundred and twenty-five thousand of those people either live in or within ten miles of Augusta. The other hundred thousand live in these twelve rural counties, a distance which is approximately one hundred and thirty miles by

sixty miles wide, pretty well scattered with no population density, counties ranging from two thousand with the next largest county being eighteen thousand.

Q Are you also affiliated with the Medical College of Georgia?

A Yes.

Q And what is that affiliation?

A Okay, the affiliation is that I hold a title there, Clinical Associate Professor of Psychiatry. We, the hospital and the division, also have a contract with Medical College, so that students in the— during their rotation in psychiatry, residents in psychiatry, residents in family practice, rotate through our hospital.

Q All right. Now, would you describe, please, Doctor, the admission policies for the hospital, with specific reference to voluntary admissions of children and adolescents.

A Specifically to those. There are the following ways that I see it that we can be approached regarding admission. This might simplify going through all the admission policies. First of all we can receive a court order for the admission of a child. Generally we are notified by the court or by some type of case service worker on this, and the child is brought to the hospital. Upon this type of admission the child is always admitted for an evaluation and the court is notified within [5] a reasonable period of time, usually one to two weeks. That is one type of admission. The other type of admission we want to talk about is voluntary admissions to the hospital. In voluntary admissions to the hospital, most of the time the people who are seeking admission would be the parents. This is not necessarily always true, it could be a guardian

or this kind of thing. Insofar as is possible, all of the children, prior to any admission, are brought to the C.A.A.P, or Children and Adolescent Program. We use the initials C.A.A.P.—C.A.A.P., which is part of our mental health center. This part is located in a separate building on the grounds of the hospital, where they are evaluated prior to the admission. This program was opened in April of 1974. We have statistics from April of 1974 to November of 1975 that shows that we evaluated three hundred and fifty-eight patients in this program. Forty-nine were admitted to the hospital, and three hundred and nine were either treated as an out-patient or some other alternative to hospitalization was used.

Q Doctor—do you have those statistics with you?

A I have this. I called and got those from my secretary since they left those out and I knew we had them. (Indicating notes.)

Q Who prepared those figures, Doctor?

A These were prepared by—basically prepared by Doctor Dorothy Wood and her staff, who is the director of our children and adolescent program . . .

Q Excuse me, the director of the program at the hospital, or the community level?

A She is—she is the director of the overall child and adolescent program. The sub-parts are in-patient care, for [6] which the in-patient unit chief, who is a Master's degree nurse, Mrs. Mamie Hammock, and the director of the community program is a Ph.D. psychologist, Doctor Jessie Hawk.

Q So for all the voluntarily and non-emergency admissions, they would be screened first by the community component of the program, is that correct?

A Right. There are an estimated—and all we can do is estimate this—in the past—same period of time from April of '74, there were approximately twenty-eight admissions where these children were brought, mostly by their parents, to the hospital, after five-thirty P.M., and they were admitted to the hospital for an evaluation. We have some bar graphs, statistics somewhere—you have them—I have them here, showing how long admissions were to the hospital, etcetera.

NOTE: (Defendant's Exhibit Number One-A was marked for purposes of identification.)

Q All right, Doctor, would you identify Exhibit One-A?

A Yes. This is a bar graph representation of the length of stay in terms of days in the hospital spent by patients in the children and adolescent year—children and adolescent unit during the fiscal year 1974-'75.

Q And you were discussing, just before we introduced that, admissions for evaluation.

A Uh-huh. (Affirmative.)

Q Does the graph show that?

A What I was showing here is that each one of these blocks represent a patient for this period of time, and it may, [7] instead of—we can count them, I guess, since I didn't write this down—one, two, three, four, five, six, seven, eight patients stayed from one to five days, sixteen patients stayed from six to ten days, eleven patients stayed from eleven to fifteen days, twenty patients stayed from sixteen to twenty days, eight patients stayed from twenty-one to twenty-five days, six patients from twenty-six to thirty days, six patients from thirty-one to thirty-

five days, thirteen patients from thirty-six to forty, six patients from forty to forty-one days, three patients from forty-six to fifty days, nine patients fifty-one to fifty-five days, three patients fifty-six to sixty days, four patients sixty-one to sixty-five days, three patients sixty-six to seventy, two patients seventy-one to seventy-five, two patients seventy-six to eighty, four patients eighty-one to eighty-five, the next patient—there was one patient who stayed from ninety-one to ninety-five, three patients ninety-six to a hundred, one patient a hundred and one to a hundred and five, three patients a hundred and eleven to a hundred and fifteen, there was one patient that stayed from one twenty-six to one thirty, one, one thirty-six to one forty-five, (sic) one, one forty-one to one forty-five, one, one forty-six to one fifty, one, one fifty-one to one fifty-five, one patient one sixty-one to one sixty-five, two patients one seventy-six to one eighty, and one patient two hundred and fifty-one to two hundred and fifty-six days.

Q Okay. Now the ones for these short periods of time, like say less than two weeks, would that basically be your evaluation?

A These are—these are primarily evaluations and short-term [8] treatment patients. Many times we feel that—we personally have a philosophy that children should stay in the hospital no longer than necessary, and we have, as you see, a fairly large number of kids who are out, certainly within two weeks to sixteen days.

Q What procedures and steps are gone through when a child is evaluated at the community component?

A Okay. At the community component, which we will see any patient during the day they call, or if people feel they can wait till the next day, or they can walk into the

program itself, a person is seen by an intake worker. This always occurs. If we are doing a complete evaluation at that time—the person is always seen by a psychiatrist. A complete psychological evaluation on this child may or may not be done on that given date depending on whether it was an emergency or not. There is a decision between the team members as to what is the best alternative for this particular individual, be it hospitalization, out-patient treatment, or other alternatives which would be used.

Q Who would be involved in that team decision, Doctor?

A The intake worker who is either a Bachelors or Masters level individual, the psychiatrist, the director, who is a Ph.D. psychologist, and the testing psychologist, who is usually a Masters degree psychologist.

Q After their evaluation, if they felt like hospitalization was indicated, would they be making a recommendation to the in-patient component, or would it be an actual admission decision?

A They would be making a recommendation to the parents of this particular child.

[9]

Q And then would the papers be sent—if the parents decided to apply, then the papers from the community component would be sent to the hospital?

A Oh, yes. Basically it's all the same program.

Q It's all . . .

A We are a little unique in that we probably, I think, have the most unified system as far as community-hospital program.

Q Would a separate decision be made by a psychiatrist within the in-patient unit?

A No. The psychiatrist who evaluated is the principle psychiatrist on the in-patient unit also. There are consulting psychiatrists that come to the in-patient unit, but he is the principal psychiatrist for both the community program and the in-patient unit.

Q Would a psychiatrist always see a child in the community program, or might he be evaluated . . .

A No, the psychiatrist would always see the child within the community program. This is one of our prerequisites. Let me add at this point, that a consulting psychiatrist is always present at the staffing of this child, which gives us a second psychiatrist opinion, and this is always true.

Q When does the staffing occur?

A The staffing of the patient always occurs within ten days, attempted seven days, from the time of admission. Staffings are held weekly, and therefore the longest possible period would be—the staffing is held on either Thursday or Friday, I'm sorry, I'm not sure which day, but the longest possible time that could ensue between the complete staffing [10] of this patient, the treatment plan, all this is spelled out in the policy, would be if the child was admitted the first of one part of the week to the last of the following week.

Q And who would be involved in the staffing of each case?

A Involved in the staffing of each case are the following individuals. The in-patient chief, Ms. Hammock, the out-patient community chief, Doctor Hawk, the unit

director, Doctor Wood, the team chief of the particular unit which houses this child, the psychiatric social worker assigned to the unit, the psychiatrist, which is Doctor Clark, and one of our three consulting psychiatrists.

Q And a staffing occurs each week . . .

A Uh-huh. (Affirmative.)

Q . . . in regard to each patient?

A Right. And the attempt, of course, is to have the child staffed the same week. Obviously if he came a day or two days before staffing he would get staffed the next week.

Q Would you identify Exhibit Two, please?

A This — these are mimeographed pages from the policy manual of the children and adolescent unit, pertaining to the philosophy, the plan of service, the admission, the treatment plan, etcetera for the children who are in the hospital.

Q Does it include a written statement of the admission policies . . .

A Yes, uh-huh.

Q . . . discussed? Does it include any material with regard to the treatment of the family of the child who is admitted?

A Yes.

Q What is your policy with regard to family treatment?

[11]

A Our policy in regard to family treatment is that we make every effort possible for every child who is admitted into the hospital, to have the family involved in treatment. We have a weekly group meeting of the parents who are there as well as individual sessions with the social worker or with others of the family members. We discourage, almost, the admission of a child unless we can get the family to participate in this. Now we sometimes would have to admit the child, but we use every mechanism to try to get the family involved in this treatment process.

Q Would you have any opinion or estimate, Doctor, with regard to how many natural parents or families do not participate in treatment?

A Yes, about ten percent.

Q And this is after you've tried to get them involved?

A Yes. I think sometimes it takes a little bit of elaboration. We have about ten percent problem families in this respect. I don't think we give up. Sometimes we have to catch the family even if we may have released the child from the hospital and they're bringing the child to the out-patient or community portion we try to get them into treatment, even though we couldn't during the one, two, three weeks the child was in the hospital.

Q Do you find any problem with regard to parents being reluctant to take the children back home after you recommend discharge?

A On rare occasions we do. I'm sure we could recall a—two or three or four episodes during the last three or four years where this was a problem, but it's rarely a problem.

[12]

Q Even with regard to the majority of that ten percent that don't participate in treatment?

A Right. This is the kind—the ten percent is the kind of thing, like the parents keep finding excuses why we can't come, or I can't get off from work, or this kind of thing.

Q Would you identify Exhibit Number Four?

A This is the utilization review plan for the Georgia Regional Hospital at Augusta and includes all units and programs including the children and adolescent unit.

Q And how does that process differ from the staffing process?

A A utilization review is essentially a review program using the patients' medical record to ascertain that hospital-wide policies, goals and objectives, which are spelled out by the hospital, by certain Federal regulations concerning Medicare and Medicaid, are being met.

Q And who conducts the utilization review?

A The utilization review? This is conducted by a committee, with the superintendent and the clinical director being the chairman and co-chairman of this committee, with physicians and other professionals being appointed to this committee. It meets monthly. We brought, and we may want to xerox some of this stuff—but we brought the minutes of the meetings, and the only way to do this would be to xerox the pages—for instance showing the involvement in specific meetings. This was the last one, the November meeting has not been typed and put in here yet, but we notice, for instance, in the October meeting that Doctor Hawk, who we've identified previously, "informed the group that the explanation of the [13] patient's right on the children's unit will be documented by the social worker on the progress note sheet. The medical records department is documenting this information on

the back of the admission sheet. We also noted that Doctor Hawk has asked that the children and adolescent community services center records be included in the utilization review. These are out-patient records, so to speak, to be included in the utilization review. It was the consensus of this committee that these records be incorporated in the monthly review." Of course, it lists which records are.

Q It is a random selection of records for each . . .

A Right. Right. Except that there's a number of days that the patient is in the hospital, and I forget this number, we'll have to dig it out of here somewhere—various time periods that these records have to be reviewed. This is a Federal requirement of Medicaid, and we therefore try to treat all patients equally, so at some of these intervals, whatever it is, a hundred days or something like that.

Q So all cases would be reviewed at least that often?

A Uh-huh. Now I would point out, as it's spelled out in the policy, that on the unit, during the weekly—there is a weekly conference, an on-going conference on each child or adolescent who is in the program, because a treatment plan has been devised initially with a goal as to the time of release, an expectations, and each week a conference goes over this to see, you know, if we're meeting the goals or if the treatment plan needs to be checked, and this kind of thing, [14] so basically an in-patient child is reviewed by a team conference consisting of these same members each week.

Q Is one of the goals of that team conference to try to make release plans?

A Yes, but essentially release plan concepts are made

as part of the initial treatment plan when a person comes into the hospital. It's currently felt, that in your initial treatment plan, you should also be planning for the release of this patient, with some idea as to how long the person would be hospitalized, and this kind of thing, and therefore we use a weekly monitoring system to follow this treatment plan.

Q Now would you identify Exhibit Number Three, please?

A Yes, Exhibit Number Three is a list of all individuals who have been admitted to the Georgia Regional Hospital at Augusta since its opening, who were less than eighteen years of age. It's through age seventeen. It gives the date in which they were admitted to the hospital, the date in which they were released, whether they were directly discharged, placed on convalescent leave, and when, if they were placed on convalescent leave, they were directly discharged from the service, the building they were in, ages and other things like this, and we went through the records and have noted on the side to whom this particular person left the hospital or was released to, the parents or service worker, or what-have-you.

Q Initially, was this a printout from the computer at the hospital, is that correct?

A Right.

Q And then notations in hand were put on by manually checking . . .

[15]

A Right, the medical records. We then pulled all of these charts and went through this on this side. We simply used a computer using an age factor to make the original printout. And there is, attached to it, a code sheet which

will identify, give you, I guess, instructions on how to read that bunch of numbers.

NOTE: (Defendant's Exhibit Number Five was marked for purposes of identification.)

Q Would you identify Exhibit Four, please?

A This is the utilization review plan for the entire hospital which also includes children and adolescent programs.

Q This is the policy that we've been discussing . . .

A (Nods in the affirmative.)

Q . . . is that correct?

A We've been discussing two policies, really. There is the specific policies pertinent to what we're talking about from the children and adolescent unit, which is in one folder; this is the utilization review plan, which is a specific requirement that covers the whole hospital including that unit.

Q And this is the one in which cases are selected at random . . .

A Uh-huh. (Affirmative.)

Q . . . each month . . .

A For the utilization review committee, and it spells out how this committee is formed and . . .

Q And would you identify Exhibit Number Five, please?

A Exhibit Five contains the admitting physician's admitting note and the social history of all children and adolescents who [16] are hospitalized by eight A.M. December 1st. I think there are twenty-three or twenty-four in there.

Q What is the size—the number of beds in your C&A unit?

A Maximum number of beds is forty.

Q And as of December 1st you had twenty-nine patients?

A On the morning—well, we took this on the morning of the first, we had—I think there's twenty-three there.

Q Oh, twenty-three, excuse me.

A I believe that's correct. There may be twenty-four or something. We run an average for that unit, average daily census of about twenty-seven.

Q Are the children and adolescents combined together physically?

A They are—they are housed in a building which has four segments. One segment is designated for family living. This segment of the building is designed as much like home surroundings as possible. Children who are in the hospital for a period of longer than approximately ninety days, live in this unit. Another unit is for younger males. These are males who are generally less than thirteen years of age. We do have flexibility in that a very small immature fourteen year old might be placed there, or a very large husky twelve year old might go. Another unit houses what we—generally older females, or if a younger female were admitted she would be on that unit, but another definite one is the older males, which are males generally thirteen through sixteen or seventeen years of age.

Q Now could you just describe a little bit more in detail the differences between the family living section and the main [17] portions of the unit?

A Okay. The main portions of the unit where patients are admitted according to sex and age within the living confines of the unit, we consider more our diagnostic unit, our acute treatment unit, this kind of thing. One difference is it's typically furnished with institutional-type furniture such as we see in this room, as compared to the other one, which as a very home-like atmosphere with curtains, wooden tables and this kind of thing. The other—the main unit is staffed—the primary staff, nurses, attendants, etcetera, are on a shift-type basis. We try to use a house parent or parent image type of approach in the family living unit.

Q Is there also a school room?

A The school is a part of our program not located in this building. We have a school which has six or seven different classes where children are geared through age—soon after admission as possible, this might be day two or three—the child is fitted into the appropriate classroom where he stays during the usual school day, you know, from eight or eight-thirty to two-thirty or three, or something, assuming he can, or he may be there only a few hours a day, and this kind of thing, but a school is a part of our program.

Q Do the children and adolescents attend school together?

A They attend school together but there are seven different class categories. We've got something like basically a first, second and third grade, this being a small number of kids; then there's a fourth and fifth grade; sixth, seventh and eighth grade, ninth; tenth; eleventh; twelfth.

[18]

Q How many teachers do you have?

A We have one for each classroom . . . teachers. We use our—we either have a teacher's aide, or by virtue of the children being there we use a nursing assistant-type person to serve as an aide, or as a principal for the school.

Q One of the contentions in this case, Doctor, is that there needs to be a judicial proceeding prior to the commitment of children to the hospitals. In your opinion as superintendent, do you see any necessity for a judicial proceeding as a screening process prior to the admission of children?

A No, I don't see any reason for this. There are children who are admitted by this process. My contention for feeling this is not necessary is, first of all I think any program, and certainly we try to do this, no one should hospitalize a child unless this is in the best interest of the child and the total family situation. The goal should always be immediate treatment and release of this child back into the family setting. The big handicap, it would seem to me, if we had a judicial process, would certainly be immediately, in any type of emergency situation, where this would require time, and secondly, if we assume that we have any validity at all in which children should be admitted to the hospital, I wonder about the feasibility of putting the parents through the added necessity of going through a judicial process. It would be rare indeed for us to ever put a child in the hospital whereby the parents didn't want to. This would be the one time, and I can only think of one occurrence where we're used it, where we felt this was in the best interest of the child, and [19] had the Family and Children Services workers apply for an admission to the hospital, so certainly one of the things that's going to be necessary to help ninety-plus percent of our children is the cooperation of the parents

both in participating in treatment and following their wishes and this kind of thing.

Q That's all the questions I have.

EXAMINATION BY MR. TARUTIS:

Q Doctor Kuglar, you indicated that—that for the initial admission there is an evaluation team as part of the community component of the C.A.A.P., is that correct?

A (Nods in the affirmative.)

Q Where do they obtain the information that they rely upon for their initial evaluation?

A Well, the information, obviously, would depend upon the circumstances, but the information in general would come from the parents of the child and the child itself. Now there may or may not be court service workers, or D.F.C.S. workers or these kind of people involved in the case, so they would gather as much of this information as they can from these people, so it would obviously depend upon why the child was coming there, whether the parents were calling up, or a referring physician might make it, and we would get some information from him as well.

Q When a child comes to the community component, I think you said he basically comes from or through the community health clinics in the outlying area first?

A Yes.

[20]

Q This is ninety percent of the cases?

A Right.

Q What would be the normal situation for someone coming from the furtherest county that your regional hospital would cover? How far would they have to travel to the community health clinic and approximately how far is your hospital?

A Right. That's—all I can do is give you a hypothetical example using this county and this kind of thing.

Q Okay.

A The furtherest one would be the two southern counties, which are Emanuel and Screven counties, Sylvania and Swainsboro. Now let us assume that the parents or a D.F.C.S. worker wanted a child seen, whether they wanted—may call and say they want the child in the hospital and this kind of thing. In these counties our first line worker, of course, are the public health nurses and some general mental health workers that we have out there. We try to look in on a situation right then. We have teams that go to these clinics once weekly, therefore if it wasn't an emergency, they could be seen by this—by a team consisting of a psychiatrist, a nurse and a social worker who goes to this county. If by the phone it was felt that any sort of an emergency existed, then they would bring the child to the mental health center for an evaluation.

Q The—the team—let me see if I have this right. The team would then leave the regional hospital and go to the local community mental health clinic . . .

[21]

A Right.

Q . . . for an appointment to evaluate or interview the juvenile or adolescent or child . . .

A And the family. Let me take a minute or so to clear this up. We have two geographic areas. All right, our adult programs, or our general programs, so to speak, are on this geographic area. We're primarily talking about the rural counties now.

Q Right.

A Okay, now this is different from this child team. We have a general psychiatrist, board eligible, unless he has gotten his certification within the last few weeks, a psychiatric social worker, a nurse; they are scheduled to go to each of these counties once a week. They are following patients, seeing patients, and adults or—and/or children in this clinic, so that the public health department, or an agency such as D.F.C.S., is the normal way, or a family physician—in which normal way somebody would get linked in with the mental health services. What—since we have these public health nurses there that we work with closely, we try to get these people, or sometimes the D.F.C.S. worker, you know, immediately involved in that county. If it's not an emergency, when our regional team goes out on a scheduled day, they will see this person. If there's any feeling that there is an emergency, we would get this person to a mental health center at Augusta, the seventy mile distance, that day or the next day, this kind of thing.

Q Pardon me for interrupting, but what would you mean by an emergency? You probably should define that term.

[22]

A What might we mean by an emergency?

Q Right.

A Where parents have found an adolescent suicide

note, or if some attempt at suicide, there seems to be a great deal of panic on the part of the parents. We consider this an emergency. This sometimes happens.

Q So then after the evaluation team interviews this person, the family and the child or the guardian and the child, they would—if they then decided that institutionalization might be indicated, would be their next step?

A You mean out on the regional . . .

Q Right.

A To send the child to the mental health center.

Q And then they would go through the process that you described?

A Of evaluation, right, of gathering up as much data from the child, the parents, and other people or agencies as we can get to validate or assist this, family doctor, D.F.C.S. worker, court service worker, public health . . .

Q How would you—how would you get that information?

A We generally get that information by telephone.

Q Who would do that, the intake worker, or the . . .

A Well, I think they sort of may split this up. If we've got a child like this with more than one person to call, they might split this up. Basically a Masters level psychologist is usually the person in the childrens unit who tries to round—that person and a social worker, these two people sort of split it up, but we might have all of them according to a given case.

Q When we were talking about the admission procedures earlier in [23] your direct examination, you mentioned, or at least I understood from your testimony, that

you understood that—that we were discussing it in the context of forcing the institution to take the child rather than acting as a buffer to the institution from being required to take the child.

A I'm sorry, I'm not sure I'm following you.

Q Okay. Let me rephrase the question. Do you feel that it would be helpful, as part of this intake process, the initial review by the community component, that as part of the team, or as part of the review procedure in regard to evaluation for commitment, there was a non-mental health related person involved in that evaluation?

A I don't know if I think it would be helpful. I don't know that we object—I would object to it in any sort of way.

Q It wouldn't be—you wouldn't see it as being harmful or detrimental?

A Uh-uh. (Negative.)

Q Do you—what about the—after the child is then admitted, as I understand it, you said there would be a consulting done—a staffing done within approximately seven to ten days after the admission, depending on what day the child was admitted to the institution?

A Yes, and I think this depends upon the complexity of the given child and this kind of thing. As I said, our goal is to have this staffing on the same week that he comes in, and there are certain cases where he may come in the day before staffing and be staffed at the staffing the next day. The maximum time he can wait is till the staffing the next week, in other words, [24] that's the maximum length of time.

Q All right. And basically, the people involved in the

staffing are all health professionals, as I understood it, there is the psychiatric social worker, psychiatrist, counseling psychiatrist . . .

A Yes. I would say in general they were all health professionals. Now, it depends on your specific definition . . .

Q We're using it in the broad . . .

A In the broad sense of the word, that is true, yes.

Q Are there ever—at that staffing stage, are there ever any outside individuals involved, such as a teacher, member from the community, someone along those lines?

A No, not at this particular staffing. Now we—the one thing we will do is that we would—we sometimes encourage parents to be at the particular staffing, and as far as the teacher or this kind of thing, we hope that we've made every effort to gather some of this kind of information prior to the staffing. But as far as I know, there have never been any of these kinds of people at the staffing itself. I would say again, that I would find no objection whatsoever to a non-mental health professional being present at the staffing.

Q The . . .

A We do have, at the staffing one person that was left out. Each—we have a system for patient's rights and this kind of thing, and each building has a particular employee whose—has the primary job—and at staffings, if you'll look under patient's rights and stuff in the policy manual . . .

Q Right, which is part of Exhibit Two.

[25]

A Yeah. But we—these people are certainly there. One of their approaches is to make sure that this patient, be

he adult or child, it's not different with us, that his rights are protected according to the Georgia Code and this kind of thing regarding patients' rights and policies.

Q I'll show you part of the packet marked as Exhibit Two, at the top of that page, which is labeled patients' right. Would you mind reading that first paragraph, referring to . . .

A "The patient, although a minor, is a citizen of the United States of America and the State of Georgia. He is, therefore, entitled to every right and privilege accorded minor citizens of the country and state as specified under the laws governing the rights of mental patients." Is that what you wanted?

A Right. Who is the person that's assigned to represent or act as—I'm not sure of the term you used—act on behalf of the juvenile or child . . .

A You mean the name of this person?

Q No, not the name, but what is their status within the overall institution, a social worker, a technician, psychiatrist?

A Let me—this will vary. First of all, an individual is assigned, that this is a primary job of the entire hospital, at the present time this happens to be a clinically trained chaplain, and he has this assignment. Now each building—at the time—these change, but at the—each building has—each cottage, a person for that particular cottage to link in to this one person, since he couldn't effectively see through the whole hospital, and at the time these are elected periodically, these people are elected by the patients [26] on the unit. There is an election where the patients select the nurse, the nursing assistant, or this kind of thing . . .

Q Would that include the C.A.A.P.? Or what I refer to as—what we've been referring to as the C.A.A.P.?

A Uh-huh. Uh-huh. (Affirmative.) Right, now I could call and find out—I can't name the particular person there . . .

Q That's all right. That person would be elected by the children on the ward?

A Uh-huh. (Affirmative.)

Q The children—I will use the term children . . .

A Okay.

Q . . . to refer to children and adolescents unless I indicate otherwise.

A And then throughout the building there are large visible signs in each building telling you who the person is from this unit and telling you that, say, Chaplain Stout is for the entire hospital.

Q Okay. And the—in addition to—your patient rights indicate that a violation of those rights will be grounds for dismissal and they involve representation and informed consent among others. Has there ever been any problems with the individual who is acting as the—under this section as a patient advocate, the elected representative in terms of asserting what they regard as the best interest of the child against other staff members within the institution?

A No, I don't think so. There have been many times when these people have, through their process of coming to the Chaplain, made specific complaints or recommendations and brought— [27] Chaplain Stout and this person making this then brings this to our general staff meeting of the hospital, and we have, you know, discussed this

and take corrective action and this kind of thing, but I don't know if there's ever been any problem connected with it or any sort of retribution against an employee or this kind of thing.

Q Would there—is there, to your knowledge, any individual who acts as a patient advocate from outside the institution, who, you know, could work with the individuals already assigned?

A The only people that we know here is the Georgia Legal Aid Society, who has come to our hospital representatives in Augusta, and they have been through the hospital, they are welcome there any time, they have made a film—we have closed circuit audio-visual system throughout our hospital. They have made a film themselves, different from our film, informing patients of their rights, and this film is shown periodically several times each week. They're told how they can get in touch with these people, and this kind of thing.

Q Do you welcome that, or do you see this as . . .

A No, I welcome this. I think the people there at Augusta will tell you we welcome them with open arms.

Q Why would that be?

A Why would that be?

Q Yes.

A Because I'm in favor of it.

Q In favor of having outside representation . . .

A Sure.

Q . . . for the individuals . . .

[28]

A Sure.

Q And that would include children and adolescents?

A Sure.

Q You mentioned that in a certain percentage of cases, approximately ten percent, there is an occasion where the parents will not participate, if I'm correct?

A Uh-huh. (Affirmative.)

Q In those cases, or in any other cases, is the opportunity or the potential for conflicts between the child who is in the institution and the parent, both in terms of either the initial entrance into the institution or the eventual release of the child?

A I'm not quite sure I specifically understand the question. Can you give it to me again?

Q Well, I can try. Could there be a conflict in that the hospital would not desire to release a child or adolescent to the parent because the child—the parent may not be ready to receive the child, although the child would be well enough to be released?

A No, I don't think so. I couldn't see this sort of thing. One of the problems we have sometimes in this case is in getting the parents to take the child back. They, in essence, don't want the child, and they are running from us and our efforts to try to work out a specific family inner-action that's gone on in this respect.

Q Would that same sort of situation that you described, the parents running away, I think is the way you put it . . .

A Uh-huh. (Affirmative.)

[29]

Q . . . be present during the admission process itself?

A No, I don't see how it would be present during the admission process. Very often what has occurred here, is that the child is brought to the hospital sometimes, by the judicial process, through the court systems, and the parents feel like they didn't have any part in the admitting of this child to the hospital and aren't going to have anything to do with it. There are often—is an amount of hostility and antagonism between them and the child which has reached the point where they don't want to accept this child, and the big problem is very often not getting the child well enough to go home, but getting these parents to essentially, you know, even take this child. And on one or two occasions we had to go back into the court or through D.F.C.S. to get a disposition made. There haven't been a lot of these, but they do occur. I don't see any sense—you know, I'm not trying to hide that that sort of thing does occur.

Q Uh-huh. So following up on that, in your last point, what action—maybe you've already stated it, but what action do you take—do you have any recourse if the parent does not want the child or is running away . . .

A Generally speaking, in this case, we would link in with the D.F.C.S. worker as far as doing something about this child, to get them out of the hospital, either as far as making a foster home placement of some type with this child, or seeking judicial help to get the parents to take this child or something.

[30]

Q You said two points, let me follow up on each of them, so that I can try to understand both. As to the

seeking of some sort of foster home placement or group home placement, have you had fortunate experiences in being able to locate that kind of placement within a reasonable period of time?

A They ave very tough to locate. I think the thing we're fortunate in is that we've only had to locate one or two out of several hundred admissions. If we had very many to locate, it would be very difficult, because even the one or two we had, it took us some period of several weeks . . .

Q It took you several weeks?

A Yeah, to locate. And remember—as I say, we've had very few of them, so I could see a potential problem there, where if you needed several of them.

Q What would you do—hypothetically, what would you do if it took you more than several weeks, and your treatment plan and your staffing had indicated release?

A Okay, we would have no choice except to keep the kid until we found adequate placement. I know of no other choice that we would have available to us. One particular case, the parents apparently left the state. The kid was placed in the hospital and — I believe by the courts, we can seek out this case—but apparently the parents couldn't be found, and the child was ready to go, and it took several weeks to find—you know, I don't know, three, four, a couple of weeks to find a foster home for this particular child. But I think we have no choice, and of course, we would be as active as possible to find this placement.

[31]

Q If—your second point was that the possibility of

seeking some sort of judicial release to get the parents to take the child back . . .

A I think, and now this is not—I'm not a hundred percent sure, but I think there was one case where, when the D.F.C.S. worker was involved in this thing, it got into the courts that—the court system essentially insisted that the parents take their child back. I believe that there was this one case. It's one of these things two or three years ago, and I think I remember this.

Q Let me ask you this because I am somewhat confused. We're talking about parents that place the child in an institution and then—and I realize we're talking about a limited number according to your figures—that do this, but then do not want the child back, to try to avoid . . . parental responsibilities, is that correct?

A Uh-huh. (Affirmative.)

Q Then do you feel that those same individuals, at the time of placement for the child, are desirous to have the child placed in an institution for the same reasons—for the same basic feelings that they don't want the child back after he or she has been there for a while?

A Sure, I would say that that's probably true, but let me say this, we're not going to admit the child to start with unless the admission of the child to the hospital seems in the child's best interest at the time. Now we have a lot of parents who bring the children to us wanting to place the child in the hospital for which we, you know, do not place [32] the child in the hospital but say to the parents, "We will work with you on an out-patient basis to resolve this problem."

Q Okay. And that—those decision—well, the process by which those decisions are made are done through your

criteria, there have been—these policies and procedures that are marked as Exhibit Two?

A But the essential criteria for ever placing a child in the hospital is that the child needs hospitalization. Now one could debate forever this particular criteria. I'm sure you know that, but nevertheless, the criteria is based upon the concept that the child needs to be in the hospital, not that the parents want to get rid of him.

Q But you have developed, essentially, a process through your policies and procedures, to assure that that decision—the objective of your policies and procedures is an attempt to assure than when that decision is made, it is a valid one . . .

A Right.

Q . . . that's why you have set up these policies and procedures?

A Right.

Q Now, are you aware of any similar policies and procedures of this nature done on a state-wide basis?

A No, I can't answer that, because, you know, I know of no general disbursal of information or of each place policy manual and this kind of thing—each facility has, as far as I know, a lot of these in here, but I can only speak for how we do it and not how it's done in other places.

Q And the policies and criteria that we have in Exhibit Two, were these drawn up pursuant to a directive that you received, [33] or did you do them basically on your own initiative?

A No, they are drawn up pursuant to the fact that any hospital has to have a set of policies and procedures

to operate under, and we, of course, are accredited by the Joint Commission for Hospitals, and they specifically require—and each time we have a Joint Commission survey, they go over these things, you know, spend days reading each page and this sort of thing.

Q But—okay. And these policies and procedures that you've adopted and that are written up and placed into operation, could be changed by you as—as the administrator of the Regional Hospital, is that correct?

A No. They—not specifically. Certain policies, for instance, the utilization review has to be changed by the utilization review committee.

Q No, but I'm talking solely about Exhibit Two.

A The Executive Committee of a hospital would change . . .

Q Would do this?

A Right. I don't—I cannot—a superintendent can't change policies by simply administrative action. He would certainly call a meeting and explain why he felt like they should be changed, but there are appropriate committees regarding all types of policies. You've got a policy, for instance, for control of infections in a hospital. If you're going to change something there, you've got to get the Infections Control Committee. This approach is required by the Joint Commission, by the way, for someone to be able—for a hospital to be accredited, this approach.

Q Which approach?

[34]

A The approach of having specific committees set out for particular types of policies and this kind of thing.

Q One of the things, in looking at Exhibit One-A, if I understand Exhibit One-A correctly, this chart—bar graph, indicates the total number of—well, the number of patients and the longest length of stay for a year period, is that correct? Or a twelve month period, I guess I should say, the fiscal year '74-'75.

A For a twelve month period, right.

Q And the longest time that any one child remained in the C.A.A.P. was two hundred and fifty-one to two hundred and fifty-six?

A That's right.

Q And then there's . . .

A And that covers that three hundred and sixty-five day period.

Q Right. And then there's a significant gap and it goes down to one hundred and seventy-six to a hundred and eighty days . . .

A Right.

Q . . . the bulk of which, I think you indicated here, and I'll assume this is correct for the time being, that fifty percent of the patients are discharged by day thirty?

A Right, that's correct.

Q Have you ever had occasion or do you know of, within your institution, for a child or adolescent to remain hospitalized beyond the two hundred and fifty-six day period?

A No. To the best of my knowledge, no. I would have to check this information specifically, will be glad to do it, but to the best of my knowledge that is the longest stay that a child [35] has ever had.

Q Based on that data, and assuming that you're correct, would you assume—why would that be?

A Why would what be?

Q Why would a child remain—most of the children remain in the institution for a limited period of thirty days, and a child remain there no more—for a year period, than two hundred and fifty-six—two hundred and fifty-one to two hundred and fifty-six days?

A Are you asking why, for instance, a child would remain this long period . . .

Q No, not why they would remain that long, but why wouldn't they remain there any longer than that?

A Well, that's simply the longest one that we have had to date since we opened the hospital in terms of severely disturbed children.

Q Would it be possible—I guess what I'm trying to get at, probably in too indirect a way—would it be possible for children to remain in your institution longer than that . . .

A Yes. Yes, it would be possible.

Q It would be possible?

A Yes. It is quite conceivable that we may get a very disturbed autistic schizophrenic child that could stay longer. All I can say is that we haven't had one. We have been able to get them out within this period of time, but I cannot tell you that it's—you know, wouldn't be possible. I think obviously a general statement is that the better the program [36] the shorter period of time people stay, but there is an occasional child who is extremely disturbed that must remain in an institution. There are a very small number of these, but they do exist. We have not picked up and hospitalized one of them.

Q This would be the exception, then, rather than the . . .

A Yes, and there is a small number of these kids. It should be a very small number of them.

Q Would you agree with the statement that, I believe, one of the individuals whom we have deposed over the past few days, said that it would be—that there would be a great deal of review and question if a child remained in an institution beyond a three month period?

A Well, certainly there would be a great deal of review. Beyond this three month period, there would be a constant review as to what could be done or why this child was remaining there.

Q Why would that be, in your opinion?

A Because it should be very rare for a child to have to be there. This is not saying that it cannot occur, or there will not be examples, but it should be rare enough that past this period of time there should be very close scrutiny of any and all cases where this occurs, the reasons being very specific.

Q And indicated in the record of that individual?

A Absolutely. Actually, a part of his on-going treatment plan, is an on-going process, as to, you know.

Q Talking about your on-going treatment plan, is that when—if I understood you correctly, you indicated that when the individual first comes into the institution or shortly thereafter, [37] this treatment plan is devised, is that correct?

A Right.

Q And as part of that plan, there's a—it aims at both treatment within the institution and . . .

A And release plans.

Q . . . and release plans.

A Exactly. And it's reviewed and modified weekly depending upon justification, what's going on with the kid.

Q And the family is made a part of this review at certain stages, depending on the case . . .

A The family is also seen weekly.

Q Okay, that's where I may have misunderstood you. The family is seen weekly by individuals within the institution?

A Right.

Q As part of the overall treatment plan for the individual?

A Exactly, working with the family, and also to keep the family much involved, to keep the family appraised of the situation, and to work with the family on problems which may be found in working with the child during the week.

Q Okay. In the beginning of your direct examination you indicated the number of staff that you have at the insti—at the C.A.A.P. portion of the institution. About how many cases would the chief psychiatrist of that C.A.A.P. have, the person that—I think it's Doctor Wood?

A No, Doctor Wood is the Ph.D. psychologist who is the director of all of our children's programs.

Q Oh, okay.

A Doctor Clark is the psychiatrist. He is the person primarily [38] responsible, the primary physician, psychi-

atrist for the twenty-some in-patients plus he is seeing out-patients. We have three part-time psychiatrists, one of which is a child—certified child psychiatrist. They are there for staffings, for review of the evaluation, this kind of thing, but they also have selected children and specific treatment programs.

Q What would Doctor—would Doctor Clark's patient —I use the term case load—the number of patients that he is responsible for, sees on a regular basis and treats as their psychiatrist, would that be limited to the twenty-some children and adolescents or would he — his out-patient case load—he has an out-patient case load?

A Yes.

Q About how many people would he be seeing on an out-patient basis?

A He is primarily involved in the evaluation status of the patient initially and any medication checks which come up. The patients who are being followed as out-patients, the psychiatrist who is involved or supervises these, these are usually the part-time psychiatrists which we have on our staff. I shouldn't add something, but I want to add this because I'm not sure it's written down there, but it is our policy and probably should be written down. All children who are admitted to our hospital, where this is at all feasible for the condition of the child, conditions, etcetera, we try to operate the hospital where that when we work with these kids on an in-patient basis five days a week and have them home for the weekends, and then have the parents—we then have a Sunday evening [39] session when the parents bring them back to see how the weekend goes, and approximately two-thirds of all of our kids are home with their parents for the weekends.

Q Okay. We have here, and you've been describing basically the way your institution operates, and that method of operation is set out in some detail in your policies and procedures, would you find it unduly burdensome or do you think it would be inappropriate to devise similar policies and procedures on a state-wide level?

A Oh, I don't think so. I guess I would have to say that similar policies, I think, in general should exist on a state-wide level, but we must keep in mind that there are some differences in the availability of community resources and other things throughout our state, and I think this has some bearing. Remember that we have what I think is a very adequate community center there to evaluate these children in general prior to admission.

NOTE: (Brief off the record.)

Q We were talking about your policies and regulations and we had spoken about the feasibility of doing this on a state — requiring this on a state-wide level. Do you think, as an administrator of a regional hospital, and one that has written policies and regulations, of the—that it would be feasible or practical to run a hospital your size or larger without detailed policies and procedures such as these?

A No, I think you have to have detailed policies and procedures to run the hospital, and I think that these have to specifically be detailed for the hospital in accordance with that particular [40] hospital.

Q And in writing?

A Absolutely and in writing. And widely disseminated with copies readily available, and with some guidance and follow-up that the staff know what these policies are.

Q So that they can be implemented?

A I can speak specifically about the C.A.A.P. unit since I asked the question. I'm going to do it for the rest of the hospital later. But these policies and procedures, Doctor Wood goes over these with staff members periodically and with all new staff members that come on board in that program. There is a routine going over with these people of the unit's policies and procedures.

Q The—one final question, the state statute that we're speaking of in this particular case of—simply allows a hospital to accept a juvenile, a child or adolescent, upon the request of the parent or guardian, is that correct? Are you familiar with that statute—generally familiar?

A Yes, it allows the hospitals to accept the patient.

Q Okay. And your regulations and procedures assure that that individual can be accepted only under certain circumstances?

A It can be accepted only under the circumstances that we feel he needs to be admitted, and there are occurrences, and we can bring bar graphs in forever, where an admission may take place at night or something like this when there's no way that you can have adequate staff to ensure this, but the kid goes home the next day, because he then goes through the evaluation [41] process and we, you know, get the kid out of the hospital.

Q That will do it.

END OF DEPOSITION

* * * * *

[1]

EXHIBIT 2

CHILDREN AND ADOLESCENT PROGRAM PLAN OF SERVICES

May, 1974 Revised

The goal of this program is to meet the mental health needs of children and adolescents, their parents or parent surrogates in this facility's 13-county catchment area where indicated through the use of public facilities and state funds. In the practice of short-term procedures, this usually involves the evaluation and treatment of children and adolescents considered emotionally or behaviorally disturbed. Long-term goals involve enhancing the general adjustment and mental health of the target population through the use of the briefest, least expensive, most indirect, and least restrictive intervention possible (e.g., therapeutic summer camp).

Psychiatric, psychological, social work and academic evaluations are available either through the Georgia Regional Hospital at Augusta or the Augusta Area Mental Health Center. The Regional Hospital is a 24-hour-a-day in-patient facility. The Mental Health Center is an out-patient clinic which currently operates from 8:30 a.m. to 5:00 p.m. Monday through Friday. Therapeutic services are also provided through both of these facilities.

Application for in-patient evaluation or treatment is made through the Regional Hospital's Clinical Director's Office for initial screening. This office may make referral to the Mental Health Center if the evaluation and/or treatment may be more legitimately carried out on an out-patient basis. Direct application for evaluation and/or treatment may be made to the Mental Health Center. At any point in the course of evaluation or treatment, refer-

rals may be made to the Regional Hospital's Clinical Director for any needed in-patient management.

This program offers in-patient care, milieu therapy, therapeutic education, partial hospitalization, day care, aftercare, and out-patient services. The major therapeutic modalities available include psychoactive medication, individual psychotherapy, group psychotherapy, activity therapy, parental counseling and behavior modification. Initial contact with adolescents and their families is outlined in the program's "policies and procedures".

Each patient is given a psychiatric, psychological and social work evaluation. All in-patients and, when indicated, out-patients receive an academic evaluation. No more than ten days following their completion, the results of these evaluations are pooled at a multidisciplinary staff meeting led by the team physician. At this time a treatment program with specific therapeutic goals is formulated. This treatment plan becomes a part of the patient's permanent medical record. Also, at this time, a date is set for review of the treatment plan. The frequency of review and time interval between reviews is set by hospital policy. At these reviews, the tentative discharge date, which was set at the initial staff meeting, is either confirmed or a new discharge date is set. This decision is based upon the patient's progress [2] and the extent to which the goals of the treatment plan have been met. The patient's status with respect to the planned discharge is discussed with the patient and his or her family.

The Children and Adolescent Program is a "unified" program in the sense that its director has responsibility and authority for all phases of the program. The director

also maintains direct or indirect supervision of all personnel in all phases of the program. These phases include the in-patient facility, any day care or partial hospitalization, the therapeutic education program, and the out-patient and after care facilities. This provides for a free flow of communication among the staff of the various phases. Continuity of care is also enhanced for patients who may flow through various phases of the program.

Parental or parent surrogate involvement is encouraged throughout the patient's evaluation or treatment process. In some instances, individual parental counseling sessions are scheduled. Weekly group therapy sessions for all parents are scheduled. A monthly parent conference is held for more didactic presentations. Periodic parent-teacher conferences are held in the therapeutic education phase of the program. Several "special events" are scheduled throughout the year for mutual participation by patients and parents. Weekly "social hours" are scheduled in the in-patient facility upon return of patients from weekend passes. Structured play activities are provided at the out-patient facility for siblings of patients and this is scheduled at the times during which patients and parents are in therapy sessions.

Various other services are also available to patients. Dental services are available through a full time dentist employed by the Regional Hospital. Minor medical and surgical procedures can also be performed by this facility. Any other indicated, more extensive medical-surgical or dental procedures and any special assessments are available through various other facilities in the area by contractual arrangement via the office of the Superintendent

at the Regional Hospital. Emergency admission to the in-patient facility is available on a 24-hour basis (see procedure and policy). Aftercare is available to in-patients at the Augusta Area Mental Health Center, its satellite clinics and various satellite clinics of the Regional Hospital.

From time to time various staff members of the Children and Adolescent Program serve on advisory boards and task forces for other community agencies. The program also provides practicum experience for students from other community agencies. Examples of agencies involved include the Medical College of Georgia, Augusta College, Augusta Area Technical School, Veterans Administration Hospital. Examples of types of students involved include nursing students, education students, child development technicians, undergraduate psychology majors and psychology interns.

[3]

The Children and Adolescent Program maintains liason with school systems, Department of Family and Children Service, and Court Service Workers in a 13-county catchment area. Liason is also maintained with the Regional Youth Development Center which serves approximately the same 13 counties and with the state Youth Development Center located in Richmond County. The team's social workers maintain communication regarding the patient's current status, progress and the plans for future treatment and discharge with all these agencies excepting school systems. In the latter case, liason is maintained by the program's Child Development Technician. Application for admission to the in-patient facility for evaluation

or treatment is made to the Office of the Clinical Director at the Regional Hospital. Arrangement for out-patient evaluation or treatment is made through the office of the Director of the Children and Adolescent Program.

This facility is organized along the lines which have featured both a department/services sytem and a team system. Administratively, lines are along a department/service basis. Clinically, program personnel function as a team. General clinical guidelines are established by the program director in consultation with the heads of the departments of the various services represented in the program. Specific clinical therapeutic decisions and practices are carried out by two treatment teams, one for Children and for adolescents. Each of these teams is led by different psychiatrists (see "policy and procedure").

The roles and responsibilities of staff members in meeting the program's goals and objectives are delineated elsewhere in "policies and procedures".

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

CHILDREN AND ADOLESCENT PROGRAM

ADMISSION TO PROGRAM

June, 1973

In-Patient:

A. Scheduled:

1. Upon ascertaining the need for admission, the Clinical Director's Office will assign a bed and a date for admission. On the date scheduled for admission, the patient will report to the Medical Record Department where he will be formally admitted to the facility.
2. Medical Records will notify the unit clerk or charge nurse of the patient's arrival and readiness to report to the unit.
3. The unit clerk or charge nurse will notify the physician, Social Worker, and unit staff of the patient's presence in Medical Records and will assign an appropriate staff member to attend the patient and his family.
4. A staff member from Medical Records will escort the patient to the unit, or, when necessary, the charge nurse will send an appropriate staff member, keeping in mind that this interaction is the first formal contact with the unit personnel.
5. Upon the patient's arrival on the unit, the physician, Social Worker, and staff will be notified of the patient's arrival.
   a. The physician will admit the patient to the unit, writing the tentative treatment plan and appropriate orders.
   b. The Social Worker will interview the family or representative explaining the program to them and answering any questions they may have at the time.

   c. The unit clerk or charge nurse will see that appropriate forms are signed, that all clothing and valuables are appropriately handled, and that the patient is searched prior to admission to the living quarters. The unit clerk also notifies the school and the Food Service Department of the patient's admission on the unit and schedules routine lab work and X-rays.

[2]

B. Emergency:

1. If a patient is admitted to the unit as an emergency admission during regular working hours, he will report directly to the Medical Record Department. The Clinical Director will determine whether this is a warranted emergency admission. If so, the patient will be admitted by the Medical Record Department and the same procedure will be followed as for a scheduled admission. If a patient needs emergency admission after working hours, the physician on duty will make the determination for admission and the patient will report directly to the unit. The following day, the patient will report to the Medical Record Department for admission and the same procedure will be followed as for a scheduled admission.

C. Evaluation:

1. A patient may be admitted to this facility by request from the Juvenile Court for an evaluation of his mental status. The patient will follow the same routing procedure, however, he will be admitted for five days during which time he will receive psychological testing, academic testing, psychiatric evaluation, social work evaluation and any other evaluation deemed necessary. This information will be forwarded to the Court by the Medical Record

Department at the end of the five days and a recommendation will be made as to whether this patient needs further hospitalization and treatment. If so, he will remain in the hospital. If not, the patient will be released to the Court.

D. Without Parental Consent:

1. An adolescent patient may be admitted to the hospital without consent or knowledge of the parents. The same procedure will be followed for this admission as for a scheduled admission. The patient will be encouraged to tell the staff any information necessary for treatment such as the names of his parents and why he wants this information withheld from them. His refusal to give this information, however, will not prevent him from being admitted to the unit.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

/lp

CHILDREN AND ADOLESCENT PROGRAM

PHILOSOPHY

CAAP, with the sun as its symbol, is designed as an "intensive treatment program" in which major emphasis is placed on accurate diagnosis, realistic treatment goals, and the idea that all experience is a learning experience. Consequently, the program staff seeks to maximize experiences which may have a positive impact on the child or adolescent and his family through formalized therapy or therapeutic interactions stemming from healthy exchanges which occur in the course of participation in the program's activity oriented milieu.

Committed to a multi-disciplinary approach, the staff recognizes and respects the contributions each discipline has to offer, and operates as a "team".

Since the team concept is also extended to include the patient's family and community, the staff encourages active participation by relatives and community agencies in working toward a healthy adjustment for the child or adolescent participating in the program.

Further, the staff, aware of the impact of behavior on others, attempts to serve as models for the patient and his family.

/s/ DOROTHY Z. WOOD, Ph.D.
DOROTHY Z. WOOD, Ph.D., Director
Children and Adolescent Program

[1]

CHILDREN AND ADOLESCENT PROGRAM

PATIENT RIGHTS

The patient, although a minor, is a citizen of the United States of America and the State of Georgia. He is, therefore, entitled to every right and privilege accorded minor citizens of the country and state as specified under the law governing the rights of mental patients.

Primary rights, to be protected at all times by the staff; the violation of which may be grounds for dismissal, are:

1. Confidentiality
2. Representation
3. Informed Consent
4. Communication and Visitation
5. Protection of Person and Property

CONFIDENTIALITY

A. Release of Information

1. Written

   A written release of information form must be signed by the patient's parents or representatives before any information may be released to anyone other than a sister state institution. Medical Records releases all written information with the exception of the school's academic report which is sent from the Academic Supervisor's Office.

2. Verbal

   Only authorized program staff may release verbal information concerning a patient to other than the patient's family. Authorized staff are:

   1. Unit Director
   2. Psychiatrist
   3. Social Worker
   4. Psychologist
   5. Charge Nurse

Patient Rights

6. Child Development Technician (as it applies to school placement or plans)
7. Academic Supervisor (as it applies to school placement or plans)
8. School Nurse (only for physical reasons)

[2]

Under no circumstances may any other program staff member in any way communicate any information concerning a patient or his family unless he has been specifically authorized to do so.

REPRESENTATION

It is the responsibility of the program Social Worker to serve as the agent for the patient and/or his family whenever a violation of a right may be questioned as outlined under hospital policy.

Further, at the time of admission:

1. The unit clerk will review with the patient's parents or representatives the patient's rights. She will, also, answer any questions they may have concerning program policies governing:

   1. correspondence and communication
   2. Visitation hours
   3. Valuables

INFORMED CONSENT

Insofar as possible, the patient and his family should be informed about his treatment, medication, and progress. This is the primary responsibility of the physician but may be delegated.

No research which involves the patient directly will be conducted without his or his parent's or representative's consent which shall only be requested after a full

Patient Rights

and complete explanation of the nature of the research, and future use of the information obtained.

All research must be approved by the hospital Research Committee before it can be initiated.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

[1]

CHILDREN AND ADOLESCENT PROGRAM
TREATMENT PLAN

October, 1974

A. Admission

Diagnostic and Treatment Conference:

The importance of this conference cannot be overstated since it is the heart of the Children and Adolescent Program. Consequently, all staff who attend should make every effort to be prompt and prepared to contribute in their area of expertise.

All patients admitted to the program Monday through Friday will be staffed the following week at the appropriate conference.

Children	Wednesday, 3:30
Adolescents	Thursday, 3:30

B. Review Diagnostic and Treatment Conference:

At the admission Diagnostic and Treatment Conference, a tentative discharge date is set. One week prior to this date, a full staff review of the patient's progress is conducted and the discharge date is confirmed or a new tentative discharge date set.

Routine progress reviews are conducted weekly. Review staff conferences are held

Children	Wednesday, 3:00
Adolescents	Thursday, 3:00

C. Conference Staff Composition and Roles:

a. Psychiatrist

As conference leader, the psychiatrist pulls from the data a coherent picture of the patient, his family and their problems, establishes a working diagnosis, decides on the treatment modalities, sets a tentative discharge date, and either interprets these to the patient or designates the responsibility.

b. Social Worker

The Social Worker has responsibility for a comprehensive social history. She also functions as a liason between the program staff and any community agency staff involved with the patient, inviting them to the conference if indicated, etc. In cooperation with the psychiatrist and staff, the Social Worker interprets the conference findings to the patient's family.

[2]

c. Psychologist-Ph.D., Psychological Technician

Responsibility for administering, scoring and interpreting in writing all tests of a psychological nature is shared by the Ph.D. and technician. Results of testing are presented at the diagnostic staff conference by the technician.

d. Child Development Technician

Responsibility for administering, scoring, and interpreting in writing results of all academic tests as well as the presentation of these results at the diagnostic conference. The Child Development Technician also functions as secretary for the conference, taking minutes for the patient's charts and helping the physician fill out the treatment plan.

e. Nurses

Nursing and/or behavioral observations such as peer interactions, family interactions, etc. observed on the unit are reported by a member of nursing supervision. Individual nursing treatment care plans are drawn from this staff conference, as well.

f. Teachers

Reporting behavioral observations of classroom interactions, assessment of interest level, study skills, are the responsibility of the teaching staff who is working with the patient's age group.

g. Activities

A gym representative reports behavioral observations of patient's during gym activities.

h. Chaplaincy

Chaplain intern assigned to program reports on Ethics class behavior when appropriate.

i. Dietician

Consults on special diets for patients with physical health problems. Attends staff by invitation of the Head Nurse of her delegate.

j. Psychiatric Consultants

Help in the provision of quality care through aiding in accurate diagnosis, realistic treatment plans and assumption of individual and family therapy as time permits.

[3]

k. Visitors

Other agency staff are invited in order to promote maximum two-way communication at diagnostic conference and treatment conference. The primary purpose of a visitor's presence is to assure continuity of care.

l. Therapists

Staff who function as therapists are expected to attend the review staff to report on the patient's progress in therapy.

m. Speech Pathologist

Responsible for administering speech and language evaluations. Presents results of these tests at diagnostic staff conference.

/s/ DOROTHY Z. WOOD

DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

[1]

CHILDREN AND ADOLESCENT PROGRAM
TREATMENT PLAN

October, 1974

I. Definition:

The treatment plan is a formalized statement of therapeutic goals and the methods proposed to reach these goals. They are characterized as short, intermediate and long term and are set by the psychiatrist and staff at the time of the initial Diagnostic and Treatment Conference.

A revised treatment plan is the result of review and modification of the previous treatment goals.

II. Definition of Terms used in Treatment Plan:

1. Diagnostic Interview:

Done by an M.D. or Physician's Assistant and countersigned by M.D. The parameters of this interview are:

a. Chief Complaint
b. Present Illness
c. Family History
d. Personal History
e. Mental Examination
f. Physical Examination
g. Clinical Neurological Examination
h. Diagnosis: Mental and Physical
i. Treatment Plan
j. Prognosis

2. Observation of Patient:

Noting and recognizing in the patient's medical record facts or occurances that involve the individual patient. These observations are made by nursing and teaching staff as well as other members of the clinical team.

[2]

3. Formal Testing:

A routine battery administered by Psychology staff to include psychological and academic evaluations.

4. Social Work Evaluation:

An assessment of social situation of the patient and his family resulting in a social diagnosis and social plan of care.

5. In-Facility Privileges:

The patient is permitted access to all special therapies facilities on campus (i.e., gym, library) and is allowed to participate in hospital-wide events which are appropriate to the patient's age and diagnosis. In addition, the patient is allowed to utilize the facility's grounds, athletic fields, and picnic areas for recreation or leisure.

In CAAP, all patients are always accompanied by a staff member except when being visited by parents or other authorized visitors.

6. Special Diet:

As prescribed by the physician. Example: bland, 1800 calorie, salt free, Diabetic, etc.

7. Group Therapy:

A programmatic weekly session of age appropriate group interactions led by a therapist and co-therapist. Emphasis is on group intervention to solve individual problems.

8. Special Education Services:

Assignment to an educational curriculum suited to the patient's academic, social and psychological

functioning and needs. This assignment is based on the patient's academic history, the results of academic evaluation, and the findings and recommendations presented at the Diagnostic and Treatment Conference. These services are provided in an educational facility housed separately from the patient's living quarters. The special education program and its staff are under the administration of the Director of the Children and Adolescent Program.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

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CHILDREN AND ADOLESCENT PROGRAM

NURSING CARE PLAN

June, 1973

A nursing care plan is a set of written, specific, and concrete goals drawn from treatment goals.

Emphasis should be placed on describing in writing behaviors or attitudes to be exhibited by the staff toward the patient which will aid the patient to reach the goals set for him by the treatment plan. For example: the treatment plan may have as a goal self-esteem enhancement. The nursing care plan might follow through on the goal of self-esteem enhancement by requiring the staff to help the patient to improve his appearance or by requiring the staff to actively praise the patient for small accomplishments.

I. Formulation:

The nursing care plan is intended primarily for nursing staff use, therefore, it is the responsibility of the Head Nurse or her delegate to formulate the plan.

The plan is to be written within the first 24 hours following the initial Diagnostic and Treatment Conference or Review Diagnostic and Treatment Conference.

II. Format for Nursing Care Plan:

A. Describe consisely and accurately

1. Patient behavior or attitude that is to be exhibited for each goal.
   a. short term goal
   b. long term goal
2. Staff behavior or attitude that is to be exhibited for each goal.

3. List when indicated
   a. special staff involvement (one-to-one, particular shift only, etc.)
   b. frequency and time of staff behavior

[2]

III. Implementation

A. It is the responsibility of the charge nurse to be aware of the nursing care plan and of any changes or revisions in it.

B. It is also the responsibility of the charge nurse to see that the nursing assistants are fully informed and understand the rationale for the plan and that they adhere to it.

IV. Evaluation of Nursing Care Plan

A. Charting

1. At least once per week, the charge nurse charts the patient's progress as it relates to:
   a. nursing care plan goals
   b. treatment plan goals
2. The progress report should be a reflection of staff assessment made during patient care conference.

B. Revisions of Nursing Care Plan

Revisions in plan should be made as a result of

1. Changes in treatment plan
2. Assessment at nursing care conference that staff approach has not produced the desired results.

/s/ MAMIE R. HAMMOCK
MAMIE HAMMOCK, R.N.
Head Nurse

/lp

[1]

CHILDREN AND ADOLESCENT PROGRAM
PARTIAL HOSPITALIZATION — DAY CARE

Revised June, 1974

A. Partial Hospitalization

I. CAAP Patient

An in-patient whom the staff considers appropriate for the day care program is formally released to that program after staff review and communication with the patient's parents or representatives.

On the day of transfer:

1. The physician writes appropriate orders releasing the patient to day care status as well as a discharge summary.
2. The unit clerk notifies the Medical Record Department, the Academic Supervisor, and the Child Development Technician of a change in status and the Medical Record Department prepares a chart which is maintained on the unit.
3. The Child Development Technician meets with the patient and his parents or representative to discuss school policies and procedures as they relate to day care.

II. In-Patient—Other Hospital Units

Staff from other hospital units may release patients to day care status after consultation with CAAP staff.

On the day of release:

1. The physician writes appropriate orders releasing the patient to day care status as well as a discharge summary.
2. The referring unit notifies Medical Records and the CAAP unit clerk.

3. The unit clerk notifies the Academic Supervisor and the Child Development Technician of a change in status and the Medical Record Department prepares a chart which is maintained on the CAAP unit.

4. The Child Development Technician meets with the patient and his parents or representatives to discuss school policies and procedures as they relate to day care.

[2]

B. Day Care

Patients psychiatrically in need of a day care program may be admitted directly to that program through the Clinical Director's Office after consultation with the CAAP staff and assure availability of space.

The admission procedure is the same as that for scheduled in-patient admissions with the exception that a bed is not assigned.

/s/ D. Z. Wood
Dorothy Z. Wood, Ph.D.
Unit Director, Non-Medical

/lp

[1] CHILDREN AND ADOLESCENT PROGRAM

COMMUNICATION AND VISITATION

While every effort should be made to encourage free and open communication between the patient and his family within the framework of the program and the laws governing patient rights. Visits to the patient are to be restricted to visiting hours except for family emergencies and clergy who may wish different time arrangements.

I. Visiting Hours:

A. Insofar as possible no activity should take priority over family visits during these hours.

B. The family should be treated courteously — as welcome guests and should not be forced to wait undue lengths of time after arrival before being allowed to see the patient.

C. The right to privacy should be respected during visiting hours, space and seats provided, walks around the campus encouraged, and the staff available but out of ear shot.

II. Visitation Privileges:

Since the patient is a minor, the staff must be sensitive to, and aware of, any legal ramifications resulting from guardianships or court appointed custody.

A. Adults wishing to visit the patient other than legal parents/guardians or caseworkers must be accompanied by the legal representatives or have written visitation permission.

B. Clergy who wish to visit the patient at times other than visiting hours may do so by contacting the hospital Chaplaincy Service and making proper arrangements.

III. Communication—Verbal and Written:

A. Telephone

A public telephone is available for patient use and time must be provided daily for its use.

[2]

1. If the patient has the proper number of points needed to make a telephone call, the staff must allow the patient the use of the phone during telephone time.
2. If the patient is indigent, but has the points, money from the patient fund is to be provided.
3. As with visiting, the right to privacy must be maintained. The staff must remain available but out of ear shot.

B. Mail

Mail should be delivered to the patient the same day it arrives.

Letters:

1. The unit clerk will give unopened letters for the patient to the charge nurse.
2. The charge nurse will give the letter to the patient personally.
3. Should the charge nurse suspect contraband, may insist that the letter be opened and searched in her presence. No attempt to read the letter should be made, however.

Packages:

1. The unit clerk will give unopened packages for the patient to the charge nurse.
2. The charge nurse will give the unopened package to the patient and remain present while it is opened.

3. Items which the patient may not have in his room, such as glass, should be taken from him immediately with:
   a. A full and complete explanation.
   b. Reassurance that it will be returned intact when he leaves.
   c. A clear statement as to where it will be kept.
   d. An entry on the chart.

[3]

C. Personal Property

Since it is the nature of childhood not to fully understand the concepts of personal property, the staff must be diligent in guarding a patient's property for him by:

1. Protecting him from others who might wish to take items which are rightfully his.
2. Providing storage space that is his alone.
3. Helping him to remember to return items (a sweater from the cafeteria, a swimsuit from the pool, etc.).
4. Making clear to him when items are given to him permanently (Christmas presents, etc.).
5. Reporting to parents through proper channels of communication when items have been lost or destroyed and how this happened.

D. Personal Protection

Any form of physical or mental abuse of a patient by a staff member is inexcusable and must be reported at once to the immediate supervisor. Not to do so will be viewed as aiding in the abuse.

[3]

Communication and Visitation

At those times when a patient must be physically restrained, it must be done with the proper holding technique. Quite simply—slapping, pinching, hair pulling, verbally threatening the patient in order to control him, is a firing offense.

Mechanical restraints and/or seclusion are never to be used as a means of discipline. The only acceptable reason for ever using mechanical restraints or the seclusion room is the patient is out of control and in danger of hurting himself or others. Medical orders must be written and documentation made each time restraints or seclusion are used.

A full explanation must be given to the patient by a staff member, making it clear that the patient is not being punished.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

CHILDREN AND ADOLESCENT PROGRAM
CRITERIA FOR DISCHARGE

June, 1973

The decision that maximum program benefits has been reached is ultimately determined by the clinical expertise of the psychiatrist with consideration being give to consultation with the treatment team about:

1. the attainment of individualized treatment goals.
2. Such factors as:
   a. availability of foster home placement, if needed.
   b. situational problems within the home,
   c. readiness of community institutions such as school systems or retardation centers to accept and place the patient.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

May 11, 1973

M E M O R A N D U M

TO: All Units

FROM: Dorothy Z. Wood, Ph.D. (/s/ DZW)
Unit Director, Non-Medical

SUBJECT: Patients Released to School Day Care Program from Other Units

To provide optimum medical coverage for the patient's protection and to insure adequate communications regarding disposition of day care students, we would like for the following procedure to be observed.

When a student-patient is staffed and recommendations for day care are made, the Child Development Technician is to be notified.

A statement regarding the date day care begins, the name of the principle therapist, or whether or not the student will be followed by Aftercare and the date of the first appointment should be made.

The Child Development Technician should be contacted, also, for an appointment for the patient's parents to be held on the date of release to day care in order to discuss day care and school policies and procedures.

At the time dispositions are made about the patient regarding academic placement, promotions, or release from the school program, the physician following the student at that time will be contacted to write appropriate orders.

DZW:lp

GEORGIA REGIONAL HOSPITAL AT AUGUSTA
CHILDREN AND ADOLESCENT PROGRAM

June, 1973

PARENT'S QUESTIONAIRE

METHOD: On admission a parent or guardian will be given a booklet containing the questionaire along with permits for seclusion, smoking, off campus, authority to release child, and authorization to release information. This is to be returned to the social worker at the parents' earliest convenience.

RATIONALE: To obtain optimum information regarding developmental milestones of the child or adolescent. To provide the family with information regarding practices and policies of this unit that will affect their child doing his/her stay here.

/s/ Mamie R. Hammock
Mamie R. Hammock, R.N.
Head Nurse

CHILDREN AND ADOLESCENT PROGRAM
PROGRESS NOTES

July, 1973

Progress notes are a method of condensing:

1. Numerous behavior notes, reviews, interviews and conferences into a written declarative statement regarding a patient's progress.
2. These notes should present a flow of ideas consistent with the treatment plan and provide a basis for revision up to diagnosis and including discharge plans.

Method:

Those members of the clinical staff who are actively involved with patients on a therapy level are to write progress notes of their interactions:

1. Physician
2. Nurse
3. Group Therapist
4. Individual Therapist
5. Psychologist
6. Special Therapist
   a. Chaplaincy
   b. Vocational Rehabilitation

Notes should be written at least weekly for the first month and no less than monthly thereafter.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

CHILDREN AND ADOLESCENT PROGRAM
SUPERVISION FOR THERAPY

November, 1974

In order to provide less experienced therapists guidance, instruction and support in their efforts to conduct group and/or individual therapy and to provide top quality patient care, untrained clinical staff must be supervised by a program psychiatrist.

Method:

Only the supervising psychiatrist may excuse a therapist from a supervisory session.

Each therapist must attend the weekly group session led by the psychiatrist in charge of patient care.

Each therapist should use these sessions to discuss therapeutic problems, ask for suggestions and generally comment on the flow of his/her group or individual session.

The psychiatrist gives feedback on quality of therapy, needed changes, recommendations for improvement and suggest literature to review in regard to specific incidents.

/s/ DOROTHY Z. WOOD
DOROTHY Z. WOOD, Ph.D.
Unit Director, Non-Medical

March 12, 1975

GEORGIA REGIONAL HOSPITAL AT AUGUSTA
UTILIZATION REVIEW PLAN

1. Objective: The objective of the Georgia Regional Hospital at Augusta Utilization Review Plan is the maintenance of high quality patient care and improvement in the effective utilization of hospital services.
2. Organization and Composition: The Chairman and members of the Utilization Review Committee shall be appointed yearly by the Superintendent in such a way as to assure broad representation of the medical and other professional staff, with none of the members having a direct financial interest in the hospital. No physician shall have review responsibility for any case in which he (she) was, is, or anticipates being professionally involved. The Committee Chairman will have served at least one year as a member of the Committee prior to being appointment Chairman. As determined by the Committee, some review functions may be delegated to a trained and qualified non-physician (hereafter referred to as the Utilization Coordinator) who is directly responsible to the Committee.
3. Frequency of Meetings: Meetings of the entire Committee will be held at least monthly. More frequent meetings by the entire Committee, subcommittees, or individuals will be held at the discretion of the Chairman of the Committee.
4. Minutes and Reports of the Committee: Minutes and records shall be kept of all activities for which the Committee is responsible. Records shall be maintained to show at least:

Kuglar Defendant's Exhibit Number Four
JMW 12/5/75

a) The number of cases reviewed by the Utilization Coordinator and Committee physicians in each category (preadmission, admission or extended stay), identified by case number.

b) A listing by chart number of cases in which a question has been raised concerning utilization, with the disposition of such cases.

c) The actions of the Committee and administration regarding studies, procedures, recommendations, etc.

All of the above minutes and records will be considered confidential and will be available only to the Committee, the Executive Committee, the fiscal Intermediary, and the State Agency. They will not be available as part of "discovery" or other proceedings associated with litigation.

5. Criteria for Admission and Extended Stay Reviews: Length-of-stay and level-of-care criteria to be used in the evaluation and encouragement of appropriate utilization shall be selected, modified and approved by the Committee, and shall be readily available to all members of the medical staff, whose suggestions will be welcome. These Committee approved Review Criteria shall include admission criteria, recommended extended stay review dates, checklist and narrative descriptions of clinical conditions considered by the Committee to obviously indicate medical necessity for acute hospital care, and guidelines for use by non-physician staff in expediting the day-to-day functions of the Utilization Review Committee. The Committee may also, as its [2] discretion, decide confidentially to review with particular care the cases of certain physicians and/or selected diagnosis or procedures which may tend to be associated with unnecessary

utilization. Such action by the Committee will be kept strictly confidential and definitely does not constitute criticism or censure. The Review Criteria may be modified as necessary by majority vote of the Committee at any time.

6. The Committee will make every reasonable effort to cooperate with the fiscal Intermediary, State Agency and other groups having a legally required interest in assuring appropriate utilization, while consistently upholding the established principles of patient-physician confidentiality and individual privacy.

7. Admission Reviews: Admissions of all Title XVIII and XIX (Medicare and Medicaid) patients and other patients as described elsewhere in this Plan shall be reviewed within one (1) working day of admission except that, as determined by the Committee, cases of certain physicians or with certain diagnosis may be reviewed prior to admission. Using the approved Review Criteria generally available to the Medical Staff, the Utilization Coordinator and/or Committee physician(s) will consider at least the following information in carrying out this "admission review".

a) confidential identification of the patient, eligibility status, and date of admission

b) diagnosis or symptom(s) recorded on admission

c) physician's plan of treatment as described in the admission note and/or orders

d) where appropriate, justification for emergency admission

e) other supporting material, including history, physical, nurses notes, laboratory and x-ray data, etc.

On the basis of the "admission review", using Committee approved Review Criteria, admissions will be

classified as "medically necessary" or as "questionable". If the admission is considered "medically necessary" an initial "extended stay review date" will be assigned. If the admission is "questionable", further review procedures will be carried out, in the order felt most appropriate by the Committee Chairman:

a) Consultation with the attending physician (whose opinion shall be given great weight) will be obtained.

b) Further subcommittee or full Committee consultation may be obtained.

c) If available, optional telephone consultation may be obtained with the fiscal Intermediary, Medical Care Foundation or PSRO.

After such further review, if hospitalization is felt to be "medically necessary" an "extended stay review date" will be assigned by the Committee. However, if after further review, the final determination of the Committee or a subcommittee of at least two physicians is that hospitalization is not medically necessary, the Committee or subcommittee shall give prompt oral and written notification within two (2) working days of admission (or within one (1) working day of application if a preadmission review) to the hospital, attending physician, patient, the patient's next of kin, and (for Medicaid cases), the State Agency. Such notice will state clearly that further stay is not considered medically necessary and therefore is not payable by the program involved. [3] Patients may, of course, elect to be hospitalized at their own expense and a determination of "not medically necessary" by the Committee must not be interpreted as a criticism of the attending physician or as an order for the patient to be discharged. An attending physician may have an adverse decision reviewed by the full Committee, on request.

8. Extended Stay Reviews: In approved psychiatric admissions, the "initial extended stay review date" will be on a day representing the 50th percentile (median) for the length of stay norm for a specific diagnosis as locally determined. The "initial extended stay review date" for psychiatric patients, however, must be scheduled no later than 30 days from admission. All subsequent "extended stay review dates" will occur at intervals of ½ the median length of stay thereafter. For example, for a diagnosis in which the locally determined length of stay norm is 60 days, the initial "extended stay review date" will be on the 30th day or earlier, and if the patient continues to be hospitalized, every 15 days thereafter until discharge.

   Starting 2 working days before the assigned "extended stay review date" a further evaluation of the patient's clinical status, the attending physician's plan for further management, and his reasons for recommending further inpatient stay will be carried out by the Utilization Coordinator and/or Committee physician(s), using the same Review Criteria and consultation alternatives used in the initial review as described in the preceding paragraph (7). If it is clear to the Utilization Coordinator, using the approved Review Criteria, that continued stay is necessary, a future "extended stay review date" will be assigned.

   If a specific medical complication or additional definable medical problem has developed, the appropriate section in the Review Criteria will be used to assign the "extended stay review date". In no case, however, will the Utilization Coordinator assign an "extended stay review date" further than 7 days in the future.

   In cases where the Utilization Coordinator is unsure as to the necessity for continued stay, or the clinical picture is so complex or unusual as to fall outside the approved Review Criteria, the case will be referred for Committee physician review. As a result of this physicians review either an "extended stay review date" will be assigned or the "further review procedure" described in the preceding paragraph will be instituted. If the final determination of the Committee or subcommittee is that continued hospitalization is not medically necessary, the Committee or subcommittee shall give prompt oral and written notification within 2 working days of initiation of the "extended stay review" to the hospital, attending physician, patient, the patient's next of kin, and (for Medicaid cases), the State Agency. Such notice will state clearly that further stay is not considered medically necessary and therefore is not payable by the program involved. Patients may, of course, elect to remain hospitalized at their own expense, and a determination of "not medically necessary" by the Committee must not be interpreted as a criticism of the attending physician or as an order for the patient to be discharged. An attending physician may have an adverse decision reviewed by the full Committee, on request.

9. Medical Care Evaluation Studies: Medical care evaluation studies are done on a regular basis to promote optimum quality of care and efficient economical use of health care resources. Studies will emphasize analysis of patterns-of-[4] practice rather than individual variations. As a result of these studies, recommendations for changes beneficial to patient, staff, hospital and community will be made as appropriate.

Subjects for Medical Care Evaluation studies may be chosen from existing topic list, as a result of the Committee's recognition of suitable subjects, or on request by the Governing Body or Executive Committee. At least one study will be completed within each calendar year, and one will be in progress at all times. The studies (which may be done in conjunction with, or primarily by other hospital committees) will be accomplished by analyzing data such as that obtained from any one or a combination of the following sources:

a) Medical records or other appropriate hospital data;

b) Internal and external organizations which compile statistics, design profiles, and produce other comparative data;

c) By cooperative endeavor with a PSRO, fiscal intermediary, other providers of services, or other appropriate agencies.

The Committee's report of the results of each Medical Care Evaluation study shall include recommendations for changes to improve the quality of care and to promote more effective and efficient use of hospital facilities and services.

10. Reports: Reports of Committee activities and recommendations shall be made at least monthly to the Superintendent and Medical Executive Committee. Whenever appropriate, other reports and recommendations will also be made to individual Clinical Departments, the Superintendent, the Medical Staff and Business Office. Preparation of these reports is to be the responsibility of the Committee Secretary under the overall direction of the Utilization Review Committee Chairman.

11. Administration Response: The hospital administration will study and act upon administrative recommendations by the Committee, and will report such actions to the Committee on a monthly basis. A record of all actions related to Medical Core Evaluation study recommendations will be a part of Committee Minutes.

12. Administrative Assistance: All necessary clerical and support services will be provided to the Committee by the hospital administration on request.

13. Discharge Planning: In order to encourage the most efficient use of available health services and facilities, all necessary assistance shall be provided to the physician in his (her) timely planning for post-hospital care. For this purpose, the hospital will make available to the attending physician current information on all resources available for continued out-of-hospital care and will help the physician make such arrangements in order to assure proper continuity of care after discharge or transfer of the patient. The preparation and availability of this information is to be the responsibility of the Utilization Coordinator.

14. Non-Disciplinary Role of Committee: The Utilization Review Committee has no authority or power to discipline or reprimand any staff member for any alleged violation of any type. Such authority is reserved to the Executive Committee and Governing body.

[5]

15. Effective Date: This Plan becomes effective 30 days from the date of approval by the Medical Staff and replaces all previous Plans and Amendments.

16. The Committee shall carry out reviews of patients other than those admitted under Titles XVIII and

XIX as determined by Agreement among the hospital administration, the Utilization Review Committee, and the involved third parties (if any). Any such agreement shall be approved or rejected by the Medical Staff at their next meeting. The procedures for such reviews will be separately described in Amendment(s) to this Plan only if they differ significantly from the reviews described for Title XVIII and XIX patients.

Approved by Medical Staff on_____

Approved by _____ on _____

Approved by _____ on _____

MD/kf

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

MILLEDGEVILLE, GEORGIA

10:30 P.M. **DECEMBER 5, 1975**

Depositions of ANN ETHERIDGE and NANCY AUTRY, witnesses called by the Plaintiffs for the purpose of discovery and other legal purposes; taken by Lee Ellen McDaniel, Georgia Certified Reporter T-128, at the Powell Building, Central State Hospital, Milledgeville, Georgia, beginning at the time stated above.

APPEARANCES:

For the Plaintiffs: GEORGIA LEGAL SERVICES
653 Second Street
Macon, Georgia 31204
Ms. Nancy Lindbloom, of counsel

Also appearing: Mr. David Goren

[2]

For the Defendants: DEPARTMENT OF LAW
132 Judicial Building
Atlanta, Georgia 30334
Mr. Doug Lackey, of counsel

STIPULATION:

Deposition being called by the Plaintiffs for the purpose of discovery and other legal purposes. All formalities are waived. All objections except as to the form of the ques-

tion will be reserved until December 20, 1975, when they will be filed in writing to the Court. Witness and counsel agree to waive the right of the witness to read and sign the deposition.

ANN ETHERIDGE

witness, first being duly sworn,
testified on

CROSS EXAMINATION

BY MS. LINDBLOOM:

Q Ms. Etheridge, right—am I pronouncing that right?

A Yes.

Q Okay. Ms. Etheridge, have you ever been deposed before—has anyone ever taken your deposition?

A No.

Q Okay, well, we're here to do that today. The questions I'm going to be asking you I'd like you to speak from personal knowledge; if any of the answers that you're going to give to me are based on let's say an answer you've gotten from a superior like someone who's told you something or from a manual or guide-[3]line that you use in your duties, I'd like you to please mention that. Also, we're going to be recording this—the microphone is right there, so I would ask that if you are going to answer a question, please state either yes or no—sometimes the tendency is to nod, etc.

A Okay.

Q The other thing is if any of the questions that I ask you are confusing or you don't understand what I mean, please feel free to stop me and we can go into it, okay?

A Okay.

Q Ms. Etheridge, would you please state your name and your present position?

A Ann Etheridge, and I'm a Caseworker 2 with the Baldwin County Department of Family & Children Services.

Q What is your educational background; that is, any degrees earned? . . .

A I have a Bachelor's Degree from Georgia College.

Q How long have you held your present position?

A It will be nine years in June.

Q Where did you work before you were a caseworker here at Baldwin County?

A This was my first employment after college; before that I had experience in a newspaper office and various . . . I have . . .

Q Go ahead.

A No, that's okay.

[4]

Q When was your first contact with—we can refer to J.L. as Joey throughout this—when was your first contact with Joey?

A What about the last names of the parents—should I use those?

Q Yes.

A My first contact with the child or with this situation?

Q Right.

A Should I start in November?

[4]

MR. LACKEY: She asked you an "or" question and you answered "Right". She said "first contact with the child or with the situation?"

Q When was the case in your capacity as a caseworker —when was the case first brought to your attention?

A In November of 1973.

Q Have you continued to . . . has this case continued on your caseload since that time?

A Yes.

Q And you're presently Joey's caseworker, correct?

A Yes.

Q Can you describe basically—I know you have many duties in a caseworker's position, but could you outline what your duties are and your responsibilities, specifically in regard to Joey's case?

A Well, that's kind of hard to answer because although I [5] have been the caseworker who has taken care of various things that have come up with this child, Joey was never officially on our caseload or opened as a case for quite a while after my contact with him began, but as far as my duties would go, I was the one who talked, who worked with the personnel here at Central State Hospital, who talked with his mother concerning future plans for Joey or the custody situation.

Q When did you first formally adopt him on your caseload—like you mentioned the first contact you had was November of 1973—do you keep a case file on Joey?

A Yes. We have a recording system that goes into Atlanta and this is for statistical purposes, and my first form went in on him in February of 1974.

Q Did you maintain a case file on him after this initial contact you mentioned in November of 1973?

A Yes, I did.

Q Do you have other children, I assume . . . do you carry a caseload in your capacity as a caseworker?

A Yes.

Q Do you have children in that caseload who are in need of foster placement or group home placement, adoption, this type of thing?

A Yes.

Q What would your duties be if a child today were say to be assigned to you, it was your understanding that child would [6] require foster home placement—as you see your duties in your job as a caseworker, what would you be doing for that child in general?

A Well, it would depend on where the child was and his circumstances—children who are in immediate danger, where they are presently living, residing, are the ones who receive first priority for foster care, and we're a small agency and usually when children are in need of . . . come to us in need of foster care . . . I usually follow them from a protective service situation or from . . . a situation that brings us up to a need for foster care; and if we feel like a foster home is needed, we look in our community to see if we have a resource available.

Q Could you describe—you mentioned protective services—what type of situation would to you call for protective services—could you explain that a little bit further?

A Okay—protective services we usually think of in terms of abuse and neglect.

Q To such an extent that the Department would become involved—is that what you're saying?

A Yes. Complaints or reports that are substantiated of abuse and neglect.

Q And that's when in a situation such as that—is that what you were mentioning about the priority—that children such as . . . you were talking about protective services before . . . you mentioned that that would be a priority—children who are [7] in an immediate situation where they were presently residing would get priority, is that correct?

A Protective services is the priority, but when we become involved in a protective service case where abuse or neglect has been substantiated, we work to keep the child in his own home or with relatives before we place a child in a foster home, but you were talking about children who need foster care and when a child . . . when we think about placing children in foster care—those are protective service situations who are in immediate danger are the children who get first priority for foster care.

Q In your efforts to work towards foster home placement for a child, could you describe the procedure that you go through . . . in other words, what your actions would be first you as a caseworker and what your understanding is if you are not successful at a certain point at the first step, other steps that may be taken in order to secure foster home placement for a child?

A Okay. When we feel that a child does need foster care, usually a caseworker, which would be myself, our casework supervisor in a county department, and our director—the director of our county department would be aware that we feel that foster care is needed for this

child. I would discuss this with Ms. Autry, who is my field representative and if she was in agreement that foster care would be the plan for this child, we [8] would first look at our community resources to see if we have a foster home here in the community available for this child.

Q Could I stop you for one minute—you mentioned Ms. Autry—what's her position—what's her role?

A Okay—Ms. Autry is—I said field representative—but she is our Social Service Director.

Q Is she in a sense above . . . like are there many other local Department of Family & Children Services offices that in a sense are below her or for which she has responsibility?

A Yes, she supervises the Baldwin County service staff and six other counties—the service staffs of six other counties.

Q Okay—continue; you were mentioning that you would contact her?

A Okay. Any foster care placement—it's just agency policy that foster care placement go through your field representative, go through your Social Service Director—we usually call them field representatives. I had said that we look for a resource here in the community and if we don't have a foster home available, one that suits this particular child or children, we let Ms. Autry know this and then she will look within her district, which would compose of the six other counties that she supervises. If there is no resource available within this district, she would to to her regional program director, who is Ms. Juanita Black and Ms. Black would know the foster care re-[9]sources available in the region and if none are avail-

able within the region, then we would look statewide for a resource.

Q Could you explain again to the best of your understanding what that contact would be . . . when you say look statewide—after Ms. Black—let's assume that Ms. Black does not find anything in her region—who would the contact be?

A I think what happens is Ms. Black contacts the other region program directors and they, in turn, would contact by, I would probably think a memo, the other Social Services Directors under them—the Social Services Directors would either know the resources available in their counties or would . . .

Q In the process that you've just described—the steps—would you as the caseworker down in the local county level—would you actually, now you've mentioned that you would initiate the contact with Ms. Autry, would you then, in turn, also make the . . . initiate the contact with Ms. Black or do you make the one initial contact with Ms. Autry?

A I would make the contact with Ms. Autry unless it were unusual I would not go to Ms. Black or anybody higher.

Q In other words, after you make that referral, is the responsibility . . . is the primary responsibility as this goes, in other words, as referrals are made up, would you assume then that Ms. Autry would then make the referral to Ms. Black if the situation warranted or would you feel like that the responsibility and initiative was back on your shoulders, still remained [10] with you—do you see what I'm saying?

A I think so—I would, you know, Ms. Autry would

tell me "Well, I'll talk with Ms. Black about this and see if she has anything to offer, see what she has to say" and I would assume that she would do this—I would ask her at some point in time if she has not mentioned it, I would ask her what has happened with this and this situation, but I'm not sure I can answer you explicitly about responsibility because I still say . . .

Q Let me give you an example of this. We were talking about finding resources for foster home placement. Would Ms. Autry in her search with the step going up or would Ms. Black make the contact with potential resources or would, in other words, would they do the contact with other possible resources for foster home placement?

A They would come back to me if there was foster home available in another county, say it had gone all the way and someone was looking statewide; and say there was a foster home available for the child or children for whom we were looking for a resource in North Georgia—in Carroll County—I would be given the name and number of the caseworker and would call that caseworker and talk with them. Copies—telephone conversations would be written in letters and a copy of the letter would be sent to each Social Service Director.

Q If there were possible, in other words, if a foster home was located—a possible foster home—you would expect [11] that the name of the caseworker in the particular county would be referred to you and you would make the contact, is that correct?

A Usually this would be the procedure.

Q Do you use yourself, when you mentioned recruiting in your own county, do you have any policies or

guidelines or regulations, any manual that you use to help you in recruiting foster homes within the county—do you rely on any directive manual or anything like that?

A We have a child welfare manual that lists guidelines for foster homes, things you look for when doing a foster home study.

Q Do you have a copy of that with you today?

A No, I don't. In the back of this manual are several appendixes and there's one that's very helpful in listing the main characteristics that you look for in a foster home. We also had a foster parents manual put out a couple of years ago. This manual is mainly for foster parents, but it's also a good reference—a very good reference for caseworkers, supervisors, and so forth.

Q Give me as specific as possible when you talk about recruiting in your own county—what does that mean, in other words, who would you go see without specific names—the type of people, like what would you do?

A Foster home recruitment?

[12]

Q Right.

A Well, I'll just have to tell you generally.

Q Right, that's fine.

A The efforts that we have made in foster home recruitment have been through church groups, PTA groups, civic organizations, anywhere you find a group of people that we can go talk to; about every six months or once a year, we run radio spots on the air, put articles in the local newspapers, we have even put a, you know, ad in the local newspaper. Several civic groups have come to us wanting to know something that they could do connected

with our agency for the community and they have run articles pointing out our needs for foster parents or picture one of our foster parents with a little story about them, spotlighting certain foster parents and this kind of thing.

Q Okay, fine. Who would make the decision as to the . . . well, first let me ask you this. We've been talking with the term "foster care" and I realize this is a very general term—do you distinguish between various types of foster care, in other words, are there different types when you speak of foster care—are there different types and would you explain?

A Well, foster care generally means that we have taken the responsibility to place children in an agency approved home, one that we are supervising. The only different types of foster care that, when you speak of different types of foster care, what I would think of is what we say "regular foster care" for [13] those children who come to us from various situations who are in need of foster care. All of our foster homes have been studied and we know the foster homes pretty well—we feel like this child or these children could go into this foster home and make an adjustment and have it be a successful placement. Sometimes there are children with complex problems who need specialized foster care—there are a limited number of specialized foster homes throughout the state—I believe there are only twenty. These foster parents have had training—specialized training in the care of these children and their problems. They are paid more and I believe these specialized foster parents are paid whether or not children are in their homes.

Q What type of training, when you speak of training

of these specialized foster parents—what kind of training would that be—can you give me an example?

A No, I cannot say because we do not have a specialized foster home in our area, but what I have heard is that their training consists of workshops, I mean, you know, two or three days of intensive training to prepare them for the type of problems that they have been handled. Now this, I assume, would be an on-going thing, not just one training period—this would be an on-going thing with specialized foster parents every so often would receive something that would be more of a help to them. The supervision of specialized foster homes from the county department is different also. When we have children who are in [14] what we would consider just regular foster care, it is mandatory that we make one visit a month to that foster home and be available at other times when the foster parents need us or the foster child needs us. But with specialized foster care, the caseworker has to visit once a week and there are probably some other duties and responsibilities that I could not enumerate because I am not that familiar with it.

Q Is there any other type of placement for a child, when we speak of foster care, I mean like a group home—would you consider that another type of foster care?

A Well, yes, institutional foster care.

Q Would that include group homes—the term you just used—institutional foster care?

A Yes, we have a listing of group homes who have signed the Civil Rights Compliance we can work with and make plans for children.

Q You have mentioned now three types of possible placement which were I believe regular foster care, you

said specialized foster care and group home placement, is that correct?

A Yes.

Q Who would make the decision if a child was referred to you as to what type of placement would be necessary for that child?

A No one person would make the decision—it would be a joint decision. We would first have to consider what resource [15] was available for the child. Unless it's an unusual situation, our first choice for any child would probably be a family foster home, but according to what resource is available, the county department staff—caseworker, caseworker supervisor, county director with the help of the Social Service Director would decide what plan would be pursued.

Q The Social Services Director—is that Ms. Autry's equivalent position?

A Yes.

Q What procedures, again if you would, just speak from your own point of view as a local county, like as the caseworker on that level, is there any difference, in other words, what would your role be, assuming that a regular foster home placement was recommended, let's assume that was the recommendation. Would your role be as basically what you've described to me before when we were talking in general terms, terms of recruitment within the county—your role would be to try to attempt to recruit within the county for a regular foster home?

A We have in our county several foster homes which are already approved foster homes. These are our resources—our foster home recruitment is an on-going

thing—we don't wait until we have a child who needs a foster home and then go out to different groups and that kind of thing looking, so the foster home recruitment is an on-going thing. If we have a child who needs a foster home—a family foster home or some [16] other resource, and our preference is a family foster home, then we look to our community, to our foster homes which are already approved.

Q You would be directly involved, though, in that process?

A Yes, I would be.

Q Now you mentioned specialized foster homes—let's assume that a child has come to you and the recommendation is for a specialized foster home—what would your role be in that instance, in other words, if a specialized foster home was recommended—would you be initiating contacts or what procedure would you follow?

A If specialized foster home were recommended, I would go to Ms. Autry.

Q The first step would be to contact Ms. Autry?

A Yes. And discuss it with her and if she were to say, "Yes, I feel also that a specialized foster home is needed", but that's kind of difficult for me to even talk about, because from the very beginning specialized foster homes have been full with a waiting list and they have not really been a resource to us.

Q Assuming that, if you did have a child—let's assume that the recommendation was this child fit into the outline for specialized foster care, what would you do, what would your actions be—I'm trying to get a feel for what you would do in that instance ast he caseworker directly

involved. You men-[17]tioned you'd contact Ms. Autry—would you contact anybody else?

A No.

Q Would you then assume that having contacted Ms. Autry she would initiate any other . . .

A She would probably check with Ms. Black; I feel like she would check with Ms. Black to make sure that this is the situation, or that there would be no other . . . or to make sure that there is not some other alternative open that we could look into.

Q But that action would be on her level, in other words, would you be writing letters to anyone about specialized foster care or would your responsibility be to contact Ms. Autry and make her aware of this situation?

A Yes.

Q You would not then recruit within the county for specialized foster homes—that would not be part of your duties and responsibilities as opposed to regular foster homes?

A No, at one point, we were told that we could recruit a specialized foster home here in our area, but we didn't have any success as far as recruiting a specialized foster home, but I would not be . . . as I said, again, we would not wait until a child came to our attention to start recruiting for a resource, you know, we build what resources we can while we can.

Q Sure, I understand that. Specifically now, I would [18] like you to refer to Joey's case—you mentioned that your first contact with the case was in November of 1973, is that correct? Not . . . I mean . . . okay . . . the first time you heard about it, not a formal contact—we don't have

to go into that; I appreciate what you said before, but Joey's case was first . . .

MR. LACKEY: Counsel, maybe I can explain . . . she has been familiar with this case long before he came to Central State, a small community—they are aware of the situation and were aware of it before—that is what her quandary is—she doesn't know how far back you want her to go.

Q Okay—in your capacity as a caseworker for the Baldwin County Department of Family & Children Services, when is the first time that Joey's case came to your attention—in that capacity?

MR. LACKEY: Answer as best you can as you understand the question.

A I became involved with Joey and with his current situation in November of 1973.

Q Other than in your capacity as a caseworker for the Department of Family & Children Services, when did you first become aware of Joey?

A Well, when . . . before Joey came to Central State Hospital our agency was aware of some complaints in the community that were made concerning Joey and I was not the caseworker that handled this, but I worked with the woman who did. I had picked [19] up some complaints within the community because I live . . . I knew several people who lived in the trailer park where Joey and his mother were living, and some of these complaints, you know, came to me and I got . . . these people came to talk to Ms. Lloyd, who was then our Child Welfare Worker, and Ms. Lloyd had an interview with Joey's mother and felt that Mrs. Sherma was aware—she was Mrs. Lister

then—was aware of Joey's problems and was doing the best she could with Joey.

Q Let me be more specific, I think it will be easier. When was your first personal contact, you personally having contact with Joey himself at any time?

A I guess that would be about December, 1973.

Q Okay, fine. What was the background of how that meeting came about—that you happened to see him in December of 1973?

A I had been contacted in November of 1973 by Carolyn Grant, the social worker at the Children's Building, by Betty Harris, the registered nurse who was Joey's primary therapist at that point and I went to Central State for an appointment with Ms. Harris, and I saw Joey.

Q May I stop you and let's get something clarified?

A Yes.

Q Let's get something clarified right here—what is your understanding of the role that Baldwin County Department of Family & Children Services plays with patients, specifically [20] children who are at Central State Hospital—could you explain that first?

A I'll try. We are called on quite frequently from Central State and from other county departments that are supposed to handle many things that involve patients at Central State Hospital. Unless a child, speaking specifically about children, unless they fell into one of our categories for a program—for one of our service programs—we would really have no responsibility for them.

Q Are you aware of any regulations, guidelines, agreements as to . . . that would set out like what Baldwin County Department of Family & Children Services'

relationship is with, again confine it to children, with patients at Central State Hospital?

A Well, we have many federal and state guidelines, and a lot of these guidelines have to do with family income, with income . . . I didn't mean to say income again —have to do with family incomes, with their classification there, and also with children who are with other resources. Joey, or any other child being at Central State Hospital, had a social worker, a therapist, medical attention, you know, he had all of these things as resources at Central State, and until we became involved with this, unless there were a need outside the hospital, we had no responsbility.

Q Could you elaborate on this need outside the hospital? Could you be a little bit more specific on what that might be?

[21]

A Joey was placed in the hospital by his family—by his legal family. Our agency was in no way involved with that. Joey was in the hospital several years and he did not come to our agency's attention. The assumption would have been that this child was getting what he needed from the hospital or at the hospital. When they felt . . . when the hospital staff felt there was a need for our agency to become involved, they contacted us. Let me add this, too—children who are in . . . people in general, people who are in state institutions who are in other places where there are federal and state funds going are often not eligible for our resources because that is such a duplication of services, but when there is a specific need or a part that we can play, they do call on us; sometimes we will fit in.

Q Would your first step in such an instance be to investigate the situation and see if the Department of Family & Children Services would or could become involved; if it was necessary for them—is that what you're saying?

A Yes, that's right.

Q And if there was this need for help outside of the hospital, that's when you would continue, if that was found, that's when you would continue any services on the part of the Department of Family & Children Services?

A I'm not sure I follow what you are asking now.

Q Well, okay, I'll tell you what I'll do; let me summa-[22]rize what I think you said, and then you just correct me or just tell me if I'm . . . if not, please elaborate. If, as Baldwin County Department of Family & Children Services, okay, if a patient at Central State Hospital comes to their attention, what you would do as a first step would be to investigate or just look into the situation surrounding the patient and see whether they were eligible for your services? In other words, it is not an automatic, in other words, that a child, let's go with children in Central State Hospital, patients, a referral to you would not automatically mean that you would—Baldwin County Department of Family & Children Services would continue to follow that case, would automatically accept that case of that child, is that correct?

A That's correct.

Q Okay, fine—I wanted to establish that. You mentioned that your first contact in November, 1973 was from Central State Hospital personnel?

A Yes.

Q Okay—what was your understanding then of the contact—what information was conveyed to you by the Central State Hospital personnel at that time?

A The social worker in the Children's Building called me and what we talked about that day—the main thing that I remember talking about on that day was the fact that Mrs. Sherma . . . Mrs. Li—Mrs. Sherma wanted to release custody of Joey. I [23] think it was also mentioned about maybe a future plan or resource for Joey outside the hospital in the future, but at that point they were telling us that Joey was not ready.

Q Okay, would you like to continue?

A Continue with—where would you like me to go from there?

Q You had mentioned . . . We had talked about a December 1973 meeting—could you tell us like . . . and you mentioned the first contact was in November . . . what happened then, what steps were taken after you received the referral from Ms. Grant?

A Ms. Grant asked that I talk with Mrs. Sherma and I told her that I would, but I requested that Mrs. Sherma make contact, because this is involving the parents, letting them be in on the planning as much as possible and when people come to you with requests such as this, we feel like it's better to let them make the initial contact . . . to initiate contact in some way. So Mrs. Sherma did call and make an appointment; she came into the agency and I talked with her on that occasion about different ways that we accept custody of children and . . .

Q Excuse me—could you elaborate on that—what are the different ways?

A I explained to Mrs. Sherma that sometimes we do accept voluntary releases on children . . .

Q Voluntary meaning from the parent, if there is one?

A Yes, from the legal parent or parents. I explained to [24] her that we get releases through court orders, that every situation is different and that I was not entirely responsible for saying how this would be handled, and that I would discuss this with my Social Service Director and would be in touch with her to let her know where we could go from that point.

Q What was the substance—you say you spoke with Mrs. Sherma about her desire for what was going to happen to Joey—what did she express to you? In regard to his future?

A Okay—Mrs. Sherma said that she would like for Joey to be someplace other than Central State Hospital, that she and her husband had reached a decision that he could not come back into their home, that they could not function with Joey, and he could not function with them.

Q Okay. And she was coming to you in order to find out what her alternatives were given the fact that she and her husband were not going to . . . had made the decision they would not take Joey back into the home, to look to you for alternatives, is that correct?

A To us and to Central State Hospital for alternatives. One of the problems that we had with this case would have made it easier for us to work with would have been if we had been involved in this case earlier, if it had been referred to us about the time that Central State Hospital . . . the staff of the Children's Building had begun working with Mrs. Sherma.

Q How would that be, in other words, do you have a [25] regular communication going back and forth between Central State Hospital and Baldwin County Department of Family & Children Services—would it be on the initiative of personnel within Central State Hospital to bring you, make you aware of a situation, is that how it would come about?

A Yes. There was a plan made here with Mrs. Sherma to release Joey to our agency and at any time, a voluntary release of a child is given, the other party has to be accepting and Central State Hospital—the personnel there did not know, really enough about our policies and procedures and the way we plan for children—what I'm saying is that we were not involved earlier—early enough in this situation to be able to say . . . let me go back . . . Central State Hospital personnel worked with Mrs. Sherma and helped her reach the decision to relinquish custody of Joey, and at this point our agency was the only agency—there was no other alternative with anybody to release Joey. Then they contacted our agency, so we had to start from the beginning and say "This is the way it is with us".

Q Okay, fine. What was the result of your talking with Mrs. Sherma . . . did you indeed then talk to Ms. Autry about the situation, and if you did so, what was her recommendation?

A Ms. Autry was not in her position then—it was Ms. Val Weathers. And I talked with Ms. Weathers—this was such an unusual situation that she talked with Juanita Black, who was the Regional Program Director. I am not sure with whom Ms. [26] Black talked with in the state office, but I do feel like she talked with other personnel in the state office, but word came back down to me through Ms. Weathers that we could not accept a

voluntary release on this child, that we would request that the parents go to . . . go into the Juvenile Court and petition the court to place Joey in our custody, and we would . . . we were asking that we not be given permanent custody, but that we would want to accept temporary custody of Joey, because with a child Joey's age and with his problems, we really could not do anything more with permanent custody that we could not do with temporary . . . that we could do with temporary custody, do you understand what I said there?

Q Yes. Were any reasons given as to coming . . . to the best of your understanding, as to why that particular recommendation was made, that the parents in this case petition the court?

A Yes, because we did not feel that Joey fell into the category of a child that we could either accept a voluntary release on or that we could go to court ourselves and ask for custody. He had two legal parents—we did not feel at that point that he was abandoned, abused or neglected, and . . .

Q How would you define "abandon"—what does "abandon" mean to you?

A Well, "abandon" means to me that a parent has completely left a child alone for a very long period of time, that [27] parents cannot be reached, their whereabouts are unknown.

Q Does the Department in other instances, like if a child was being abandoned, does the Department, is it your understanding that as a regular course, that they do have the power to go into Juvenile Court and to request temporary custody on their own of that child?

A Yes, if we felt a child was abandoned, we could do

that; I do know that different courts have different feelings about abandonment and I know from experience that other caseworkers have related to me in instances where parents have . . . parents of infants . . . cannot be located, cannot be found, the courts are very slow to give us custody.

Q But in your experience and your understanding of what a local county Department of Family & Children Services department can or cannot do, they can if they deem the situation that a child is in let's say an emergency situation, that he has been abandoned, if they feel he's abused, like an emergency situation, that they feel in the best interest of the child, he needs to be out of that situation, that they can initiate and be the petitioner, let's say, to Juvenile Court to attempt to get temporary custody, is that correct?

A Yes.

Q You mentioned a personal contact with Joey in December, 1973—at what other times have you had personal contact with Joey, and from that I'm speaking from December, 1973 up to the present—how many times have you seen Joey personally?

[28]

A Probably, oh eight or ten times.

Q Do you, as you mentioned before, we established that you do keep a file on Joey—a file is kept on him . . . how do you get information for your file about Joey; I assume, I just asked—you mentioned you've seen him eight or ten times, in the times that you . . .

A I obtained information from his record at Central State Hospital . . . medical records, psychological nurse's notes, and this kind of thing.

Q Do you do that on a systematic, regular basis; in other words, do you request, let's say, a monthly report from Central State Hospital as to how Joey's progress, or do you receive things automatically or do you just . . . when you specifically request it?

A When I request it, when anything really significant happens, the personnel there will contact me.

Q When you say significant, could you explain what you mean by that?

A Well, if anything significant happens and . . . if anything happened with Joey's home situation, contact with a parent or someone else becoming involved with Joey . . . we worked a little bit, not thinking so much about a foster home for Joey; the personnel at Central State, speaking of Ms. Harris and Ms. Grant and I suppose his psychologist and others involved with him there felt that if we could have someone involved with Joey, just someone to take him out of the hospital once in a while, someone [29] to show some interest in him, not especially working toward a foster home placement, that this would mean a great deal to him.

Q You've mentioned now . . . we've talked about three different areas that you or Baldwin County Department of Family & Children Services, like address themselves to in the case of Joey; we talked about working with Mrs. Sherma in terms of this relinquishment of her parental rights, you've mentioned now like a sort of service . . . a social service in terms of providing him with some contact . . . was there a third area that you worked in in terms of a long range goal at his foster home placement?

A With Joey?

Q With Joey?

A I can't say that I have worked too much in that specific area because I knew right from the beginning that we had no foster homes here in Baldwin County that could cope with Joey. We might have had one possibility of a home that might have had Joey, but this home was full and was filled with younger children and we felt that we could not take the responsibility of placing Joey in a home where there were younger children.

Q Was this home that you mentioned about that you had considered, was that . . . at the time you were considering, was that in 1973 or has it been just recently or when was that?

A Well, it was not recently, but it would not have been in 1973; it would probably been more somewhere like summer of [30] 1974, spring, summer, 1974, somewhere along in there.

Q Was that the main, that you could say like in the last two years, was the primary effort then would you say, as the caseworker for Baldwin County on this case towards the . . . working with the Shermas, towards their voluntary relinquishment or the procedures whereby they would give up their parental rights and the services aspect that we mentioned before, would you consider those your primary responsibility in this case?

A Yes, I would not give one priority over the other because Joey had been on my mind like a lot of other people's minds, I'm sure; as to his wanting very badly to be somewhere else than Central State Hospital. Now our understanding of Joey's condition has been that he fluctuates in what they feel . . . what the staff of Central State feels is a readiness for another placement, and . . .

Q How did you receive this information; in other

words, when was the first time the Central State personnel spoke to you in terms of a long range goal for Joey and their recommendation in that regard?

A November or December of 1973, during some of those contacts, as to what we would work towards in the future.

Q It was your understanding that their recommendation at that time . . . that that's what Joey needed?

A I don't know if I could say it was their recommendation because I would talk with them one week and they would say that [31] Joey's behavior was fine, maybe we could work towards this . . .

Q Then other conversations that you had with Central State Hospital personnel, you mentioned records, that you looked to records at Central State—did the records indicate to you that the personnel that were involved there with Joey—needed foster care?

A The records would have been the same; the records, you know, we would get a copy of a psychological or some ward notes or something that would point out Joey's severe behavior problems, then we would get something saying that he had improved, then it would be something that he was regressing a little. What we felt like we had to to on was to whether or not a resource that we had available for Joey could cope with, how severe his behavior was or how serious his behavior problems were.

Q In the conversations or within the reports that you looked through at Central State Hospital, were there any specific recommendations in there—we talked previously in general terms about types of foster care, regular, specialized, group homes or as you mentioned, institutionalized, did it come to your attention through any of the personnel or records at Central State Hospital as to

what their recommendation was for the type of foster care for Joey and if so, when?

A I don't believe that Central State Hospital personnel was familiar enough with our foster home, foster care programs [32] to be able to say what kind of care they felt that Joey needed.

Q Let me just clarify that . . . it'll make it a little bit easier for you—I didn't mean specifically notations in their records as to what Baldwin County had in terms of foster care, but their recommendations in general as to the type of foster care that Joey needed, either with . . .

A I'm not sure that I could pinpoint anything written in my records from Central State Hospital, but I do know that in talking with Betty Harris and with Carolyn Grant, who had been the main people that I've talked with at the Children's Building concerning Joey, we have all been in agreement that Joey needs a very special foster home setting.

Q Do you mean specialized foster care, in using that, is that synonomous with very special foster home, or do you mean like a regular foster home with very understanding foster parents?

A Well, I'm saying specialized foster care, but at the same time, there may possibly be a family, just a regular approved foster home, who might be able to cope with Joey, but this would still have to be a very special, not specialized, but a very special family who have the patience, the ability to cope with a child such as Joey, who have the time and attention to devote to Joey—we have all felt that Joey needs to be in a foster home where he is the only child, where the mother has a lot of attention to give to Joey, and this kind of thing.

[33]

Q Yes, I understand what you're saying; given that, you don't recall the first time that you specifically talked with any of the personnel, either Ms. Grant or Ms. Harris, or anyone about this type of home that you know, you all agreed was necessary for Joey—do you remember the date, I mean, do you remember approximately . . . was that also maybe in 1973 or 1974?

A Well, that was probably nearer the beginning of 1974 because my contacts in 1973 were late in the year, and it probably was the beginning of 1974 when I got the material on Joey. I wanted to say . . . do I have to wait for you to ask questions or can I say . . .

Q I think we may get to it through my next series of questions, if not, you can add it on. You got the materials the beginning of 1974 and sometime in early 1974 you had these discussions with the Central State Hospital; you spoke of agreement as to this type of home described for Joey's needs—what, in your capacity as a caseworker, what actions did you then take?

A I continued to keep Ms. Weathers, who was the Social Service Director at that point, to keep her up to date on what was going on between me and the Children's Building. A copy of the material that I received on Joey was sent to her.

Q What other contacts from January, I'll specify early 1974 continuing to this date, have you made?

A In January of 1974—can you wait just a minute and let me get my notes out?

[34]

Q Sure, that's fine.

A I can't remember whether it was in . . . it was in December that I talked with Mrs. Sherma and we discussed the relinquishment or whatever of the custody of Joey at that point; and Ms. Weathers, after she talked with the people that she was responsible to said that we could not take a written release from Joey. I had an interview with Ms. Harris and Ms. Grant in the Children's Building, and this would have been either very late December or January of 1974, and explained to them that this is what had been said, that this would be our request, that they petition the court to give us . . . the parents of the child petition the court to give us custody of the child and that we would like to start off . . . we would like to have only temporary custody. We made an appointment with Mrs. Sherma and I went back to Central State Hospital and had an interview with Mrs. Sherma and Ms. Harris and explained to them again our agency's position concerning taking custody of Joey; and Mrs. Sherma at that point said that she understood and that she would talk with her lawyer about how to handle it with her ex-husband, who is the legal father of Joey; and she lead me to think that they would go ahead and initiate action.

Q Finish what you were going to say.

A I heard nothing until early May, 1974 when we received a copy of kind of a release, a voluntary relinquishment signed by Mrs. Sherma and Dr. Lister, notarized—it was not signed by [35] a judge, it was no order or . . . it was just notarized, and I sent a copy of this release to Val Weathers, who took the release to Ms. Black . . .

Q Let me just stop you and I'll let you continue in a second. What efforts did you make between January 1974 and April 1974 when you received this copy of the voluntary relinquishment to secure some type of foster home placement for Joey?

A What effort did I make?

Q That's correct.

A At this point, I was not sure that we would be pursuing a foster home placement for Joey because we were not sure that Joey was ready for a foster home. Going back to what I said . . . what I was talking about a minute ago in getting somebody else just to have an interest in Joey, to find him a resource outside the hospital, I made just some community efforts . . . to give you specific instances, say . . . would you want these?

Q Did you make any written inquiries or was this basically your just generally feeling out what was available?

A This would be within the community, so there were no written efforts. Ms. Harris, who was in the Children's Building that I've been speaking of, was doing the same thing.

Q Could you continue . . . you had been explaining up until April 1974 . . . what happened after April 1974 specifically in regards to your efforts for foster home placement for Joey?

A I have been aware all along of what our resources are [36] here in Baldwin County and there was nothing that we could really fit Joey into here, and anything that has come to my attention that might possibly be something that we could develop into a resource for Joey I have been aware of in making any efforts in the community.

Q How about in regards from January . . . again, early 1974 whenever you had the conversation with Ms. Harris

and Ms. Grant and came to the agreement that what was needed for Joey was a specialized foster home or a very special regular foster home—what efforts did you make after that time continuously in terms of specialized foster care home, let's say that specifically . . . I understand what you explained about a regular foster home and your efforts in that regard; specifically as to specialized foster home, what actions were taken by you?

A Well, Ms. Weathers was aware of the feeling of a need for a specialized foster home for Joey, Ms. Black, who was the Regional Program Director was aware of the need. When Ms. Weathers left her position and Ms. Autry came into that position, she was immediately aware of the need too—I believe this was the first case that she had anything to do with . . . directly to do with in her capacity as Social Service Director. She was aware immediately of the need. We did not have a specialized foster home in this area, we didn't seem to have a resource for one, and very shortly after that, the funds were withdrawn for us to develop a foster home in this area, and that was all we could do.

[37]

Q Did you make any written requests, other than again, like did you make any written request to anyone on the state level or on any of the levels that you've spoken about before you yourself as to specialized foster home for Joey?

A No, I would not do this—Ms. Autry would do this.

Q Okay, but you made your contact?

A Yes.

Q That's what you have done in your capacity?

A Yes.

Q Since the time we are speaking, that's since April 1974 to the present, have you continued to make attempts or efforts to explore placement-foster home placement for Joey—regular this time?

A Since when now?

Q Okay, let's go back . . . let's just start this over. From early 1974, the first time you talked with Central State Hospital personnel, agreeing as to the type of home that was needed for Joey, have your efforts been continuous since that time to seek a foster home for Joey and if so, can you specify and be as specific as possible as to what those efforts were?

A I don't know another word to use except responsibility—my responsibility, my area of working with this case as far as finding a resource for Joey, would be, finding a foster home for him would be confined to Baldwin County. I guess I can . . . or I feel like I can say that this effort has been con-[38]tinuous in that I have known continuously of our resources here in Baldwin County . . . I have known continuously of any possibility of new resources . . . we have continuously from time to time made an effort to say to somebody "Would you be interested in this child or is there any possibility that you could have an interest in this child or do you know anybody else who has . . . it has been this kind of thing here in Baldwin County.

Q You were explaining why I wanted to clarify those particular points, the Department's role in terms of their accepting or adopting custody of Joey and you were explaining that you received this paper that voluntarily relinquishment of rights from Mrs. Sherma in April 1974, is that correct?

A The paper was signed, I believe, in April of 1974, and we received it in May.

Q What happened after the Department received that?

A I sent a copy of that paper to Val Weathers, who I'm sure showed this paper to Juanita Black and I believe that it went to Ann Hunter, who is Head of Social Services in the state office, and the general consensus was that that paper was not legal, that it could not be considered a legal release. We met with Colonel Schuyler here at Central State and talked about the release and explained that Central State Hospital could not take custody of the child and that the release just really could not be considered binding or legal—Central State Hospital or our agency was not a consenting party to the release.

[39]

Q Assuming that, if you had been successful, let's say in March of 1974 and had found a foster home that would have met the needs as you defined them, that Joey require or would need in a family or foster home setting, would Joey have been placed there?

A Joey could have been placed in the foster home without our agency having custody; there are some resources that we would only be able to use, you know, with our agency having custody, but if we had a foster home, a specialized foster home, we can take voluntary requests from a parent for a foster home placement for that child.

Q That could have been done, if indeed you had come across a foster home that again, was suitable for Joey's needs—he could have been placed?

A Yes. (Directed to Mr. Lackey—can I borrow your pen?) (Directed to Ms. Lindbloom—I just wanted to make a note of something—is it okay?)

MS. LINDBLOOM: Sure. Could we just take a short break?

(BREAK IN QUESTIONING)

Q Ms. Etheridge, has it been your understanding from Central State Hospital personnel or records that the recommendation which you've spoken of in early 1974—their recommendation as to the type of foster home that Joey needed at that time, remains their opinion or remains to be what's recorded in their records at the present time?

[40]

A Are you speaking of the need for a specialized foster home or . . .

Q Specialized or very special as you say regular foster home?

A Yes.

Q In that regard, you've also mentioned the service function that you've performed in setting up . . . has your agency set up visits for Joey with other families, let's say at holidays or vacation periods and the like?

A No, because we have had no success in finding anyone who was interested in, you know, having Joey, even for brief periods of time and we have no resource for finding something for this kind of need except to go out into the community and ask and look.

Q Did you make any contacts-to the best of your knowledge did the Shermas have any further contact with Joey after late December 1973?

A I don't think so; now they could have had some in early 1974, but I don't believe any more after that.

Q Did Central State Hospital personnel inquire to you and rquest that your agency possibly set up some visits with families for Joey for vacation periods and various holidays in the last two years; that is, from December 1973 to December 1975?

A Yes, I could say two things on that matter—they did not contact us and say . . . well, what they contacted us and said [4] was "Do you have something available for this?"—and when we had to tell them that we did not, you know, they didn't like it, we didn't like it, but they were accepting of it, and that's the way things were.

Q Okay, so Baldwin County Department of Family & Children Services has not been setting up visits for Joey on vacation periods—that's not something that you've been doing?

A No, we have not. We have gotten letters from Central State Hospital, form letters that are sent out to parents of . . . parents or guardians or whoever of each child saying that the vacation paper . . . vacation period for Easter, Summer, Christmas, is such and such a time, let us know what your plans are, and we've been back in touch with them and said, you know, we'll look and hope something comes up at the last minute, but, you know, we just don't know of anything that we could plan for.

Q When you look for your general, as you mentioned, your on-going efforts you have to look for recruitment of foster homes within the county, are there certain children that you consider priority children that you consider more important than others in terms of finding a foster home?

A The one priority that we would make there would be going back to what I said previously that children who are in a home or in a living situation where they are in immediate danger would be given first priority for a foster home.

Q How many children are you presently looking for . . . I [42] realize the recruitment effort is on-going, but how many children right now that you have, let's say on your caseload, are you seeking foster home placement for besides Joey?

A On my caseload I have probably eight to may fifteen children who would be better off in a foster home.

Q What do you mean by better off?

A Well, they are not . . . these children are in their own homes; there are two children who are in a foster home, who are in a foster home at this point now, that their foster placement is not working . . .

Q If you had to take those eight to fifteen children you are talking about now, would you place a priority on . . . I'm sure it's easier for you to talk about priorities with actual children that you have on your caseload—are there children among those eight to fifteen, including Joey, that you consider a priority?

A Yes, all except two or possibly three of the children; these three children are already in a foster home, they are being given adequate care—the foster home placement is not working, but they do have a place to stay where they are cared for and protected. The other children, besides Joey . . .

Q Well, if you can relate those specific ones that you would consider on the top of the list, you don't have to

describe all of them, but if you can describe the situation of those you consider priority of the eight to fifteen cases, and include [43] Joey in those?

A No, I can't because the other children besides Joey are children who are in their own homes, who are not receiving the care that they should be receiving. Most of them are with their natural parents, maybe with one parent, the mother; she is not caring for these children as a foster parent would. She . . . they don't have the stimulation and in a lot of cases they don't have the love, and this kind of thing that they would in a foster home.

Q I'm appreciative and I think I understand what you're saying that all of these children probably need something . . .

A Can I go just a little bit further?

Q Okay, why don't you continue?

A Okay . . . let me go just a little bit further; all right, so all of these children are in about the same situation, but with this type of situation, we work with the family and try to hold it together because if there is any way we can keep that natural family together, that is the best thing, even though right now the children would be better off in a foster home, but maybe today or maybe tomorrow, there will be a tragedy of some sort and the situations in one of these families will be a real bad abuse case, you know, maybe the mother's had all she can stand emotionally, financially or whatever and has beaten the child very badly or she says "I can't cope"—then this child would get a priority for a foster home.

[44]

Q Okay, let's just take a freeze . . . a moment in time, which is right now—we have no emergencies, we have

just those people on your caseload and I'm appreciative of the fact that you are making this on-going effort to recruit foster homes within Baldwin County, that you have not had great success in turning up numbers of foster homes. Let's suppose now that you have one couple . . . you have a foster home opening and you have those children that you just described—clearly, you have to make a choice, wouldn't you, if you do have one foster opening and you have those children—that's basically what I meant by priority; can you basically tell me which of your children would get priority?

MR. LACKEY: Council, how can she answer that question if you can't be more specific about what kind of a home, what kind of couple you are talking about, what kind of resources they have? When she mentioned priority twice now, she talked about an immediate life or death type situation as being her concepts of what a priority was—I don't see how she can answer your question.

Q Yes, but I'm speaking . . . let me say if I can explain this better to you. You've had problems in securing large numbers of foster homes within the county, is that correct—is that a correct statement?

A Yes, it is.

Q Given the caseload that you have and I appreciate the [45] fact of emergency situations and that special situations arise and that is a priority in one sense. I'm trying to get a feeling from you of the caseload that you have now, that if a foster home . . . let's make an assumption, that this is a foster home, a very special regular foster home . . . you've checked it out, it's been an approved foster home and you have to make a decision as to which of the current caseload, and you've given us a detailed account of that—which of those children would

you, given the fact there are special circumstances in each of those cases?

A I think . . . is what you've asking me, if I had a vacancy in one of my foster homes here in Baldwin County, which of my children would I fit into it?

Q Right, exactly?

A Well, going back to what Mr. Lackey said, it would depend on which foster home, to me I supervise . . . I'd have to name and count off right now six or seven foster homes here in Baldwin County. I think three of those foster homes are approved for specific children. The other four foster homes the children come and go as the need is. To me, all these foster homes are . . . I'd have to say that all of these foster homes are in themselves, that the foster parents are special people because even with children who do not have problems such as those that Joey has, they are a lot of time, patience, a lot just having to give to strange children who come into your home who are not able to be . . . who have to be in foster homes.

[46]

Q Let me just zero in on this and I can save us some time. Do you regard Joey's situation and by that I mean, having received reports from Central State Hospital personnel since early 1974 that he needs to be placed in a specialized foster care home, assuming that's the situation, he's presently confined in an institution, do you consider that situation . . . how do you rate that—do you regard the necessity, his necessity for placement in a foster home, let's say as greater than the children you've remarked who are in their natural homes now and you're attempting to work with the family, the urgency of Joey's situation?

A The one advantage that we would see Joey having would be that he is in a place where he receives care, protection, this kind of thing. I don't see our agency ever being in a position where we have a foster home and would have to choose between placing Joey in that foster home or another child in that foster home. If we ever were in that position, I can't say which child would have priority.

Q If the number of slots in existing foster homes, though, is limited, would you not of necessity have to make a choice which children would remain on your caseload as your . . . continuing to look for foster homes for them, and I mean that slot would have to be filled, is that correct?

A No, it would not have to be filled. As far as my caseload is concerned as of about approximately five or six [47] o'clock yesterday evening, all my protective service cases are okay right now, you know—there are no particular crises, and if we had a vacancy in a foster home, I would not just choose to take one of these children out of this family when things are all right now and place him in a foster home. That vacancy might remain in the foster home or we might have a call for that vacancy from another county . . .

Q Is what you're saying that if a vacancy should arise that it is possible in your experience with working with the Department that vacancy may stay open for various reasons for a while, that it wouldn't automatically . . . a child would not automatically be placed?

A No, if we had a child waiting in our district or if Nancy or Ms. Black was aware of a child in another district or region who needed that home and would fit into that home, then that child would be placed in that

home, but we would not go out looking for a child to take ouf of his natural home.

Q No, I did not mean that; I meant children who are on your caseload already that you are currently aware of . . .

A Who are on my caseload?

Q Yes.

A No, not if things are going all right in the natural family, you know, if . . .

Q Have there been any vacancies in foster homes within the county of which you are aware of since January 1974?

[48]

A Yes, there have been.

Q Was Joey considered for any of those placements?

A I would . . . I don't know whether to say yes or no to that . . . let me put it this way—these are foster homes, we have one foster home who keeps only infants, they are approved to keep only infants; Joey would not have been . . . would not have been considered for that home.

Q Right.

A The other foster home—the mother had an operation on her leg, was on crutches for a period of . . . in the hospital on crutches for a period of time, and she could not have taken care of Joey or any other child during that time. We have . . . I can't . . .

Q Those are the only vacancies that you can . . . that you are aware of, that you can think of at the present time?

A Yes.

Q Since January 1974?

A Yes.

Q Would that mean that given the fact that Joey was not appropriate obviously for an infant foster care home, that he was not considered for any local county foster homes, then, since January 1974—actually consulted when there was an actual vacancy available?

A No, because we knew . . . because we knew that Joey could not go into these foster homes.

[49]

MS. LINDBLOOM: Excuse me just a second.

(OFF THE RECORD)

MS. LINDBLOOM:

Q Have your efforts changed any since early October . . . excuse me . . . late October or early November of this year in regard to Joey, in regard to the court order granting temporary custody from the Juvenile Court judge, giving temporary custody of Joey to the agency?

A At the time of this hearing, Joey's legal father came forth and did express some interest in the child. The judge placed temporary custody of Joey with our agency, but stipulated that we would look into the possibility of placing Joey with his legal father and his family. We have requested that Thomas County—that's the county where the legal father resides—we have requested that they do a thorough home evaluation, we have sent them copies of all of our material on Joey that would be pertinent to them, what background information we have on the legal father, information on his natural mother here, anything we could send to them to help them make . . . to under-

stand Joey's need and to make this evaluation. That has been done since the court hearing which was held on November 24. In October, Nancy Autry referred Joey to Child Service and Family Counseling in Atlanta and I think it was Friday before the hearing on the . . . that was on the twenty-fourth, two people from Child Service and Family Counseling came down and interviewed me and Ms. Autry [50] and the staff at Children's Building and Joey.

Q Could you explain this Child Service and Family Counseling—are they a referral agency?

A Yes, they are a private agency in Atlanta—they have a specialized foster care program and they do accept referrals from other agencies, but we understand that waiting list is long and the waiting period is long, but a referral has been made, they are interested in Joey and have been down to talk with us and to see him.

Q Other than the Child Service & Family Counseling Center's efforts as a private agency, since the time that you made the contact with Ms. Autry regarding a specialized foster care home for Joey back in early 1974, what is your understanding, or have you received any comunication or documentation that efforts have been made within the State now in terms of finding specialized foster care for him to the present time?

A All I can say to that is Ms. Black is familiar with all the specialized foster homes throughout the state, she knows that they are full and that we have a waiting list of children to go into those specialized foster homes and it has been maybe approximately two weeks ago . . . no, it was the day of the hearing, the custody hearing . . . it was a week ago Monday on the twenty-fourth that Ms. Black again stated that she had recently checked to make sure

and that they were all the slots in those specialized foster homes were full.

[51]

Q Ms. Etheridge, to your personal knowledge, have you received any written word or did Ms. Black or did any of your superiors communicate to you that Joey had been placed on any kind of list for specialized foster care or was given any type of priority for that?

A I don't know because I don't know what kind of list is circulated; I don't know . . .

Q Okay, fine . . . excuse me, why don't you continue, I didn't mean to cut you off.

A That's okay, but I just am not familiar enough with how . . . with what . . . as I said what kind of list is circulated or how that waiting list is handled. We have several regional program directors and each one of those knows which children in their counties are in need of those specialized foster homes, from there I don't know how it's handled.

Q That's fine—I just wanted to know whether it was in your personal knowledge. I have one last question for you, okay? In your efforts in locally recruiting for a foster home, if you were to be explaining Joey, if you were to give a brief description, let's say, to a possible foster home, or to people that might be potential resources for foster home placement, if you were to describe him in just a few words, what characteristics, you know . . . what would you say based on your knowledge?

A I would say that this is a twelve year old boy, would give some background about him being at Central State since such [52] and such a time, that he exhibited

while in Central State serious behavior problems, many of those behavior problems continue to manifest several of these problems.

Q What problems are those?

A Impulsive behavior, short temperedness, a low frustration threshold, wanting to have his own way most of the time. I would say that this is a child who needs extra time and attention, that he has special needs in you know, needing this extra time and attention, he would need to continue in school here at Central State or some sort of special education school and I feel like this would be more than just a regular special education classroom in the public school system, this kind of thing.

Q Ms. Etheridge, do you agree with the Central State Hospital personnel that Joey needs immediate placement in specialized foster care or a foster care home?

MR. LACKEY: There is no evidence that Central State personnel say he has to have immediate placement in a foster care home.

MR. GOREN: It's in the stipulations.

MS. LINDBLOOM: (Directed to Mr. Lackey) Do you want to see it?

MR. LACKEY: Yes, let me see it. (Examines stipulations)

MS. LINDBLOOM: Maybe it will be easier . . . why don't I quote from this to Ms. Etheridge, okay?

MR. LACKEY: What are you quoting from?

MS. LINDBLOOM: I'm quoting from the exhibits that were attached to stipulations of facts, okay? Ms. Etheridge, I refer now to [53] a June 1975 Central State Hospital summary progress note on Joey Lister, signed by Betty Harris and Odelia Gutierrez, in which they state and I quote "He is obviously suffering from some degree of institutionalization and should experience success in a loving, concerned relationship as soon as possible." Also in quoting from the psychological evaluation from Central State Hospital dated July 9, 1975, signed by Ryan Lincoln, the psychologist for the Children and Adolescents' Unit, in which he states "Continued hospitalization would not provide the emotional climate necessary to meet Joey's needs and it is my recommendation that Joey be considered for foster home placement with continued out-patient therapy.

Q Are you aware of those two reports, the Central State Hospital reports that I've just referred?

A I'm not familiar with that report from Mr. Lincoln; I don't think that I'm familiar with the report from Ms. Harris either, but my only contact with Mr. Lincoln has been very recently and nothing direct, but in talking with Ms. Harris, this is what she had said, this is what, what I feel, that Central State does not offer what Joey needs in the way of an emotional climate, that a foster home or another placement would offer him more in this area, but whether there is or ever would be anybody that could cope with Joey, with his behavior problems, or whether he would be able to adjust or be able to have another living arrangement, you know, would be in question.

[54]

Q In your mind, that's in your opinion?

A That's the way I feel.

Q Have you been aware of any visits that Joey has

made since December 1973 either on the vacation periods that you spoke about, which Central State Hospital sent you the form letters requesting, you know, noting that Christmas vacation was coming, Easter vacation was coming and did you know anybody . . . are you aware of in your record have you . . . do you have any reference to any visits that Joey made to other homes other than to the Shermas?

A Joey visited with a family in Eatonton a couple of times. I think there was another family that came to see him here at the hospital and nothing developed; now Ms. Harris arranged these but I was aware of them. She met these people through a church in Eatonton, a pastor who used to be here who now has a church in Eatonton. I'm aware that Mr. Goren had him a week during summer vacation and it seems like another weekend . . . then Thanksgiving weekend. One family contacted Ms. Harris about . . . back during the summer . . . about being interested in Joey and we arranged about three different appointments with this couple and these appointments fell through; they went on a long vacation, they both went back to school and now they say at this time they cannot be interested in Joey, and this is the way things have gone.

Q Is it your understanding of these visits that they [55] were successful; in other words, were there any major problems to the best of your knowledge from what you know about these visits, were there any major problems or were they just normal visits?

A I don't know about the visits in Eatonton, you know, what went on there. I don't remember how much of a progress report or how much was said to me about those visits.

Q Do you have anything written in the file, let's say, you've mentioned conversations with Ms. Harris, do you have anything in the file as to visits that Joey has made to other homes and as to their success or lack of success—have you kept any kind of record as to those visits?

A Nothing except maybe some narrative saying that Ms. Harris . . . Ms. Harris knows pastor; she has asked about any members of his congregation be interested in Joey and then maybe making a note that there is a family in Eatonton who is interested and will take Joey, that kind of thing.

Q In your narrative there?

A Joey is a child . . . we know what his behavior is and a lot of times just behavior that may be acting out that one family, maybe a family would feel like they couldn't cope with that was for them to take, maybe for Joey that might be pretty good.

Q Do you have any indication in your own records or your own knowledge that the visits that Joey has made since December [56] 1973 to other homes have been unsuccessful or there were major problems incurred?

A Major problems, no, I don't think so.

Q Okay. Do you yourself have any clinical or psychiatric type of background, training—child psychiatric background, psychology, specifically?

A My Bachelor's degree was in psychology, sociology; I've been to several workshops that have been lead by people who are . . . whose names are well known in the area of . . .

Q But as to any specific long term training or degrees, you do not?

A No.

Q Let me just clarify just one last thing, and that is that since December 1973 in the last approximately two years, you've had eight to ten personal contacts with Joey, is that right?

A Yes, and I will say that these contacts . . . a lot of times Joey has not even been aware of these contacts, that I would just see him and observe him for a few minutes. There was some reason behind this; ordinarily with a child in Joey's position, a child that we would be looking for a foster care placement or considering any other resource or just working with, I would have much more contact than this, but Joey was at Central State, there were many other people involved with him, and it was our feeling that another caseworker, somebody else coming in, [57] would be confusing to him—he knew who I was, he had been told that we were looking, that the agency was helping looking for a foster home; we were not going to promise Joey something that we could not come through with, so I kind of stayed, just stayed away from Joey; he had many questions about why, when and this kind of thing. Betty Harris was in constant contact with him and she handles the type of think that I would ordinarily handle with a child.

MS. LINDBLOOM: Okay, that's it.

DIRECT EXAMINATION BY MR. LACKEY:

Q During the course of the examination you mentioned that at one time you had a specialized foster home allocated to this area, is that correct?

A Yes sir.

Q Was it to Baldwin County or to the district?

A To the district or the region; at that time our regions were a little different, but it was a county area, like an eight or ten county area.

Q And this was a funded position?

A Yes.

Q And you were unable to develop a couple that could fill that position out of this region?

A Yes.

Q Do you know how long you tried?

A We must have had these funds available for maybe a [58] year. We, as I said, it would have been our county and several other counties and if we had come up with a couple in every county, we would have had to decide which would make the better specialized foster home. You know, there was just nothing available for this here in Baldwin County. We thought of taking one of our foster homes and trying to make a specialized foster home out of that home, but we saw later that we wouldn't be able to do that.

Q Did this occur during the period when Joey was in the hospital here or do you recall?

A Yes.

Q Let me see if I understand—you testified that you had a specialized foster home allocated for this region, it was funded for approximately a year, there were approximately eight counties involved, and you all couldn't find anybody to fill that position—would you answer please?

A Yes, I'm sorry.

MR. LACKEY: Thank you; that's all I have unless you want to explain.

MS. ETHERIDGE: There was one other point that I wanted to bring out.

MR. LACKEY: Go ahead.

MS. ETHERIDGE: We have talked about efforts made here in Baldwin County to find Joey a foster home—it's also been considered that Joey might be better off in a foster home outside of Bald-[59]win County because of the situation here with his natural mother, which is traumatic—it's traumatic for her but it's very traumatic for Joey and there has been much speculation and I think kind of a decision that if we could find a resource outside Baldwin County that this would be better all for Joey.

DIRECT EXAMINATION BY MR. LACKEY:

Q Is there any sort of search going on for this type of facility that you know of?

A A specialized foster home would be outside Baldwin County because there would be no resource for that here, and except for saying again that those who are responsible for placing children in specialized foster homes know of Joey's need, and there's just no vacancy there.

MR. LACKEY: That's all I have.

CROSS EXAMINATION BY MS. LINDBLOOM:

Q I have one question—to clarify that—you mentioned there was a slot for a specialized foster care home; let me just make sure I understand—do you know whether it was for specifically Baldwin County or was it for the district of which Baldwin County is a part?

A It was for the district—it was not just for Baldwin County, it was for a home to be developed in that district . . . in this district.

Q And there are eight counties?

A Our districting was different then or either it changed [60] right as that money was taken away, but it was seven or eight or probably nine counties at that time involved.

Q Can you be a little bit more specific if possible on the year, the time this funding was available—was it in 1974, was it within the last year—1975?

A No, it was not within the last year . . .

Q 1974 perhaps?

A I would probably say 1973 1974—not those two years, but say a fiscal year from July 1973 to July 1974.

Q How were you made aware that there was this slot available?

A There was a memorandum sent to us from the state office saying that this money was available.

Q Specifically that the money was available for this district?

A Yes—it was sent to all the county offices . . .

Q Within the district; okay, fine. Who did that memo come from?

A I can't remember; I think the memo probably came from the state office to our . . . to Val Weathers, who was our Social Service Director at that time and she sent the memo to each county office, in her area . . . in her region or her district. That would have been one memo that came from the state office to Val or some notification.

Q And she then in turn communicated it to you?

[61]

A Yes.

Q In that same memo, did either she or in the memo, did they outline what efforts people such as yourself, caseworkers on local county levels should make in seeking

to fill that slot, to find foster parents to fill that slot—were you given any specific instructions as to what to . . . how you might go about recruiting . . .

A I don't think so, just look in our foster homes and to look at our . . . any new applicants that we had, to make whatever efforts we could, you know, we are so badly in need of foster homes here and everywhere, it's just understood that you are continuously looking for foster homes and when you have a program such as this, we also have Emergency Shelter Care Homes, which are . . . provide very short term foster homes, they are specially funded programs that . . . specially funded homes that we only can have a certain number of, and we searched for an Emergency Shelter Care Home and for a specialized foster home we searched rather diligently during the time that money was available, just wanting to have . . . to develop that resource while the funds were available.

Q As far as your efforts within Baldwin County itself, did you contact the existing foster home parents within the county to ask them whether they had any desire to become specialized foster parents; in other words, did you send out any communication to them?

[62]

A No, I did not because I know the foster homes in this county well enough to know that they would not fit into the characteristics or stipulations that these foster homes . . . that a specialized foster home has to meet.

Q The characteristics that you mentioned before when I asked you to define a specialized foster home was the training that the foster parents in that home received such that they would be able to cope with specific needs of a child, am I quoting you correctly or am I getting the gist of your . . .

A Yes, that would be in the definition or in what a specialized foster home is, that's part of the specialized foster home—the foster home here that I spoke of thinking of working this foster home into a specialized foster home, there were some changes in the living arrangement there at the home, some changes in that family that let me know that they could not be a foster home . . . a specialized foster home.

Q Other than the existing foster homes within the county, did you make any special effort in terms of recruitment when you had knowledge of this slot; in other words, did you do any . . . you mentioned like a newspaper article or something like that, anything specifically written during the year that this slot was available through use of the media, or any other method to alert the public as to the slot and what specialized foster care was and the availability?

A I believe there was a news release about specialized [63] foster homes from the state office at one point—I don't remember when that was, there was nothing specific from Baldwin County. What we did at this point . . . during that year we did some radio spots, there was a series of articles, stories that we got from the state office on foster homes, saying if you would like to be a foster home, if you were interested, know of someone else who was interested, contact or refer. If we had advertised just for a specialized foster home, we might have been flooded with requests that we would have to weed out. By just asking for those who were interested in providing foster care, we felt like the best and most potential candidates for specialized foster homes would come forward and we could work into this.

MS. LINDBLOOM: Okay, that's all I have, that's all.

* * * * *

[1]

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION**

(Caption omitted in printing)

The deposition of ARTHUR FALEK, Deponent, taken at the instance of the Defendants; all formalities, including the reading and signing of the deposition, waived before Edward H. Lieberman, Certified Court Reporter, at the Georgia Mental Health Institute, Atlanta, DeKalb County, Georgia, commencing at 9:00 a.m., December 8, 1975.

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[2]

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[3]

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EXHIBITS

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FOR THE DEFENDANT:		
No. 1	Curriculum vitae and bibliography	5
No. 2	"Classification in Schizophrenia"	11

[4]

PROCEEDINGS

Whereupon,

ARTHUR FALEK

was called as a witness and, having been first duly sworn, was examined and deposed as follows:

DIRECT EXAMINATION

BY MS. KIRKLEY:

Q Would you state your full name for the record, please?

A Arthur Falek.

Q And where are you employed?

A I am employed at the Emory University, and my laboratory is located at the Georgia Mental Health Institute.

Q And what is your educational background?

A I have a Ph.D. from Columbia University in human variations, studying human genetics.

Q So primarily you're interested in human genetics; is that correct?

A Yes. My background, my qualifications—if that's the direction of the question—are in statistics, human genetics, general genetics, psychology. The reason that it's such a broad kind of a statement about these qualifications—I mean, people are qualified in one field or another, but the basis for the broad qualification is that when I went through for my doctorate, there were no people trained in human genetics. Columbia University didn't know what to do [5] with someone who wanted a degree in human genetics, so they felt the easiest way was to qualify you in every stage of the way, so they went along qualifying—insisting that you have to qualify in these various areas, so the people sitting on my committee were the people at Columbia University who had the qualifications to give a doctorate in each of these areas.

[Whereupon, a document was marked Defendant's Exhibit Number 1 for identification.]

BY MS. KIRKLEY:

Q Would you identify Exhibit 1, please?

A Yes. This is my curriculum vitae, indicating my professional activites, and the other pages are my bibliography—my list of publications.

Q Are those both current?

A Both are current.

Q What is the nature of your present work at GMHI and Emory?

A My present work is research in psychiatric genetics, with particular interest toward early detection of disorders.

Q Particular disorders?

A Yes. One area of interest is in alcoholism and concern with cirrhosis, and we are doing tissue studies, biochemical studies of tissues from human liver tissue, looking for the biochemical variations in patients with cirrhosis versus [6] patients with other liver disorders versus other normal individuals. That's one aspect of this study. Another study is in—we're interested in a study on reproduction in schizophrenia. We're interested in a program in birth defects in general. We have a study with the Center for Disease Control where we're following all newborns in the five county area. We're trying to identify the frequency of various kinds of birth defects in the population. We're concerned with epidemiology. We are concerned about variations in frequency over time, or with particular environmental kinds of situations, and from a genetic point of view, of course, we're concerned about recurrence so that when we give genetic counseling we can give the appropriate kind of counseling to the parents of patients with these various kinds of anomalies.

Q Are you the head of a unit that does research so that you would have some other people who are doing research with you?

A Yes. I'm head of the Laboratory of Human Behavioral Genetics.

Q And how many people work with you approximately?

A Oh, about a dozen.

Q Okay. In your work, have you had occasion to study the reliability of diagnosis in schizophrenia?

A Yes.

Q Would you describe for us, please, and eventually [7] for the Court what your findings have been?

A The diagnosis—The reliability of diagnosis of schizophrenia is somewhat over 50 per cent, and varies between 50 per cent and some 87 per cent, according to various investigators in the field. The issue that interests me was the reliability in schizophrenia versus the reliability in physical disorders, and when you look at the reliability in physical disorders, you find that the frequency of reliability is no better in a variety of physical disorders, from tonsillectomies to cardiac disease to the pap smear, or the diagnosis for cancer of the cervix, as compared with diagnosis for the particular mental illness called schizophrenia.

Q What was your methodology, Doctor, in reaching this conclusion?

A Well, this was really a library review aspect. What we did was to pull all the material from around the world to collect the data in the various languages to be able to make certain that we were talking about—that we had the basis—the data base for presenting the information, because we wanted to demonstrate that with regard to reliability in schizophrenia, it was going in the same direction now as other medical disorders, and that reliability —the direction for this kind of reliability was to improve reliability as time went on.

Q Okay. And have you published the results of this?

[8]

A That's right.

Q Would you tell us the citation, please, Doctor?

A That paper is "Classification in Schizophrenia." It's in the *Archives of General Psychiatry*, published in Volume 32 in January of 1975.

Q All right. I believe you stated that your findings were that the reliability varied between 50 per cent—

A Most of the studies varied in the 50 per cent range to about 87 per cent.

Q Would you explain how that figure was derived, 50 per cent, or what that means?

A Okay. There are three types of studies with regard to reliability that one deals with when one is concerned about diagnosis: one is concerned about the observer agreement—that is, one psychiatrist looking at a patient, and a co-diagnostician and co-psychiatrist making an independent observation, or a psychiatrist making a diagnosis and residents making a diagnosis; or there is consistency over time—that is, a patient enters an outpatient clinic first, and then goes to a psychiatric institution, and then goes to an outpatient clinic—how consistent is the diagnosis from the first stage to the last stage situation; and then there is occurrence in comparable samples—that is, patients in three wards at the same time.

Q And when you reached your figure of 50 per cent to [9] 87 per cent, I believe—

A Well, if you look down the numbers, there are very few that are less than 50 per cent. There are one or two studies—one study, I guess, in each of the categories—where the observer agreement is under 50 per cent range—

somewhere in the high 30's—but most of the studies are with much higher agreement between psychiatrist and psychiatrist or from patients going from an outpatient to an inpatient, or being looked at an inpatient facility over a course of years.

Q The third method, occurrence in comparable samples.

A Yeah.

Q Those look somewhat lower than the other two methods.

A Well, these are frequencies. Those aren't percentage of concurrence. Those are the frequencies of patients found within a hospital setting. It's like three wards of a hospital, or what's the frequency of a psychiatrist, or three psychiatrists, or whatever number of psychiatrists, seeing patients in a ward—what frequency of patients with schizophrenia did they see—and therefore, this is a different kind of number. These numbers, the greater the similarity between the numbers, the greater the concurrence, so that the first study, for example, by Pasamanick, 36,23 and 26 is very high consistency in the frequency in diagnostic categories in the three wards. The second study of the three psychiatrists said, "Okay, what did these three people see," and there's something quite [10] different there in this 29 and 22 and then the 67 per cent, and that's a very interesting kind of study, by the way, because that really is the concern of the approach that was conducted by the group with the U.S.-U.K. diagnostic project. That really was their direction. Why was there this kind of—you have three psychiatrists, and you have this kind of wide variation suddenly occur. So what they did is to start out—the basis for the study—the people

who were really organizing the study started out by developing a videotape method, and sending videotapes of patients, clear-cut schizophrenics, totally questionable kinds of categories—on videotape to groups of psychiatrists in the United States and in England, and they found differences. The most interesting study for me was the one in North Carolina, because in that study, where the psychiatrists were using fairly clear-cut diagnostic schema, the diagnoses of schizophrenia in the United States and with the patients as seen in London and in various other parts of England were very much the same. I think it was London and Glasgow, or something like that.

Q Is the North Carolina study part of the U.S.-U.K.?

A Well, all of these studies became the basis for the U.S.-U.K. study, and the U.S.-U.K. study demonstrates that when psychiatrists are trained in a similar manner, that the frequencies of schizophrenia, be it in London or New York, are the same, rather than at the kinds of extremes, like 60 per [11] and in the low 30's, and they demonstrated this by showing that when they had a trained group of London—of English and American psychiatrists trained by one team of psychiatrists, that these people produced the same frequency of patients from a population which was different from that of a general hospital type of schema.

Q Is this U.S.-U.K. study published, Doctor?

A Yes.

Q Would you just give us the reference to that?

A It's called *Psychiatric Diagnosis in New York and London*, and it's by J. E. Cooper, R. E. Kendell, B. J.

Gurland, L. Sharpe and J. R. M. Copeland and R. Simon, and it's Oxford University Press, London, in 1972.

[Whereupon, a document was marked Defendant's Exhibit Number 2 for identification.]

BY MS. KIRKLEY:

Q Would you identify Exhibit 2, please?

A Exhibit 2 is the paper of "Classification in Schizophrenia" by Dr. Hanna Moser and myself.

Q And when you are referring to the various studies that have been done—

A They are all listed on the references.

Q When we were talking about the different ways of determining reliability, we were discussing Table 3; is that [12] correct?

A That's right.

Q And in your opinion, the first Pasamanick study here indicates substantial—

A —similarity. That's right.

Q And—

A The second one shows that one of the psychiatrists diagnosed a different frequency than the other two.

Q Okay. You did review all the literature; is that correct?

A I reviewed all the literature that I was able to at that time and that I am aware of. We did the World Survey of Literature, so we tried our best to get as much information as possible.

Q And this was just published in 1975; is that correct?

A '75, that's right.

Q So you reviewed all the literature up until that time.

A That's right.

Q And what about the literature with regard to physical medicine?

A Well, the literature with regard to physical medicine shows that the consistency in diagnosis is about the same for physical medicine as it is with mental medicine, with regard to schizophrenia, for example.

[13]

Q Would that just be true for certain physical illnesses, or in general?

A Well, for all those that we could find references in the literature.

Q All the studies that have been done.

A All the studies that have been done. This is not to criticize medicine and say, "Isn't it terrible that's how inconsistent you have been." This is to say this is where medicine is today, and the point of scientific evaluation and investigations of these types is to direct the attention to what we have currently and to see that we can make—make the diagnoses, or improve the consistency in diagnosis. That's the whole point of the scientific issue.

Q What relationship did this study have to your genetic work?

A All right. Well, I really started this study—as you can see, in the beginning of the study, it's talking about the frequency of schizophrenia in the general population, because that frequency has been reported out over many

years, and most psychiatrists have learned that the frequency of schizophrenia in the general population is roughly one per cent, and I wanted to point out where that one per cent frequency came from. And I was most interested to note that when other studies were evaluated, that the frequency was about the same in other investigations as well. There were [14] eighteen studies in the mid-20's—from the mid-20's to the mid-30's—in the Austrian, Swiss, German border areas, and these studies all came to the same kind of frequency conclusion of about one per cent when the data were corrected for age. Schizophrenia is diagnosed—adult schizophrenia is diagnosed in patients usually between 15 and 45 years of age, so we're talking about an age breakdown of population, and when one corrects for age—that is, one removes all cases that are diagnosed earlier than that and corrects for the population that are living through the 15 to 45, so that it can be diagnosed at any time in that period as schizophrenia, and takes as a whole the number of cases over 45 that had been diagnosed prior to that time of life as schizophrenic, then one is really correcting to see how, and increasing the frequency to its uppermost limit. So the one per cent frequency is a fairly high frequency. The uncorrected data ranges about 0.35 per cent, plus or minus a small variance. When one looks at the data published by Yolles and Kramer at the National Institute of Mental Health some years later, one finds that their data, which is on different studies, with a much larger population basis to evaluate, they find that their frequency—uncorrected, they find that their frequency is 0.35, plus or minus a small variance as well. So it was very intriguing to me, who has been talking about genetics and schizophrenia, how consistent the diagnosis has been over the [15] course of time. Now, there has been the problem for a period of

time where, I guess because of the frustration of the psychiatric research community—where there was a broadening of the definition of schizophrenia—what we now know, with the introduction of the U.S.-U.K. studies and the videotape studies and the development of the attempt to computerize diagnostic classification, that the research psychiatric community is tightening the definition once again and going back to trying to refine diagnosis so that one becomes more and more consistent, and I think that's the approach of the scientific community at this point with regard to mental illness. That's what they're doing with regard to manic-depression. That's what they're doing with regard to other kinds of disorders as well.

Q What is the importance of that for your work in genetics?

A Well, now, if one is able to diagnose in a consistent manner, and when you get a frequency for the general population, then one can become interested from a genetic point of view about what the frequency is within families, within twins, within children adopted from families with schizophrenia. Then you can start becoming concerned about the genetic aspects. If the diagnosis is so loose that it varies all around the map, then looking at the frequency of occurrence in families becomes a very difficult and almost useless kind of exercise.

[16]

Q So this review formed the basis for the work you're presently interested in.

A That's right.

Q Did you see, say within the last 15 to 20 years, any increase in the reliability of diagnosis of schizophrenia?

A Well, I think in the last eight years—the last seven to eight years—with the new approach, with the new concern about diagnosis, and the new publications with regard to diagnosis, and the U.S.-U.K. studies, and the computerized kinds of techniques to clarify schizophrenia, that I think that this kind of approach can only improve diagnosis. Obviously, the U.S.-U.K. study showing that one has to train psychiatrists, whether they're in the United States or wherever, in the same kind of classification scheme in order to get comparable kinds of populations for evaluation if an appropriate kind of approach for improving diagnosis—and that, in turn, is exhibited by this publication of *The International Pilot Study of Schizophrenia* of the WHO, which is this publication here, which is really going in the same direction. It's saying, "Okay, this is where we are now. What ought we to do?" Now, the man who was very much involved in this kind of presentation was one of the people very much involved in developing the diagnosis—the U.S.-U.K. study to improve diagnosis of schizophrenia.

Q Would you give us the reference to that?

A This is *The International Pilot Study of Schizophrenia* [17] and it's Volume 1, World Health Organization, Geneva, 1973.

Q What is the substance and summary of that work?

A Well, the substance and summary is a call for techniques to classify by computer analysis and to talk about concordant groups of schizophrenics and evaluate those populations.

Q Your paper on Classification in Schiophrenia is basically a review of the literature.

A That's right.

Q Have you been involved in any studies yourself?

A Yes, I've been involved in studies in schizophrenia since 1949. I was the research assistant and associate of a man named Franz J. Kallmann, and Franz Kallmann was the man who developed the twin study, family method for doing genetic studies in schizophrenia. He was located at New York State Psychiatric Institute, and I was associated with him for 16 years, and left that organization to come here.

Q Okay. Would you just describe what those studies involved and what your work was, and the findings of those?

A I helped with the field work, of course. The kinds of studies that we conducted at the New York State Psychiatric Institute in the Department of Medical Genetics was that we did twin studies and family studies on various mental illnesses—various mental disorders and aging, and in tuberculosis, and we did these studies trying to specify whether or not there [18] were genetic factors in the various types of disorders. My job in these kinds of studies of schizophrenia and manic depressive psychosis was: a) to do family interviews; b) to do the statistical analyses of the data; c) to help write some of the papers; and after a period of time, to develop the studies that were going to be conducted in the department myself.

Q What were your findings with regard to the twin studies and schizophrenia?

A With regard to the twin studies and schizophrenia, what we found was that when we looked at siblings, brothers and sisters of schizophrenics, we found that our frequency rate was between 14 and 16 per cent; when we looked at twins—dizygotic twins—two egg twins—we found that the concordance rate was 14 per cent, so that

we had very similar concordance rates between dizygotic twins and siblings. When we looked at the concordance rate of monozygotic twins, identical twins, we found that our concordance rate, when we corrected for age, was 86 per cent, so that we then reported that there were high genetic—that genetic factors were very significant with regard to schizophrenia. My concern has always been what is the general population rate, because we find the various numbers in terms of the general population. That's the reason I kept going back and being concerned about it, and I wanted to get this off my back sort of, I think, because it was bothering me; what was the general population rate, and where [19] did that one per cent frequency rate come from—that's bothers me for years. Being able to resolve that problem is just one issue that makes me feel a little bit better about the data that we've been publishing. Now, this kind of information about genetic factors in schizophrenia has now been confirmed several times over. And the more recent studies are those showing that in the families in which the children are adopted out at birth, when you compare these children adopted out at birth and compare them with the children at the home of the families adopting them, you find that the frequency of schizophrenia is remarkably higher than expected by chance. So they're saying there's much evidence now from family studies, from twin studies and from the adoption studies demonstrating that genetic factors are operable in schizophrenia.

Q And you were saying the occurrence of schizophrenia in the general population is somewhere slightly less than one per cent; is that right?

A Well, the corrected data is about one per cent; it's the frequency that's been reported out, yes.

Q And then for siblings and two egg twins, it would be about 14 per cent.

A Yes.

Q And one egg, identical twins—

A Now, those are the corrected numbers. If you look at the uncorrected numbers, the data suggest that for siblings [20] the frequency is ten per cent; for two egg twins, the frequency is ten per cent; and for identical twins, the frequency is 50 per cent. Similar kinds of numbers are also shown in looking at one or two parents with schizophrenia: one parent affected, your frequency is about ten per cent; and two parents, the frequency is somewhere between 40 to 50 per cent, but closer to the 50 per cent mark.

Q Did you conduct similar twin studies with regard to depressive psychosis?

A Yes. There is a paper by Franz Kallmann on manic-depression and schizophrenia—manic-depression as well as schizophrenia.

Q Did you conduct the study for him on that?

A I was one of the people going out, and one of the people doing the statistics—certainly I had a lot to do with the statistics.

Q Do you remember the findings of that study?

A The concordance rate for monozygotic twins ranged close to 100 per cent with regard to the population, and the concordance rate for dizygotic twins, if I remember correctly, was somewhere around 23 per cent—22 or 23 per cent.

Q And what would the occurrence be in the general population?

A Lower than the frequency for schizophrenia. From a population point of view, there's a lower frequency of [21] individuals in the general population.

Q Okay. That's all the questions I have.

[Brief recess.]

CROSS EXAMINATION

BY MR. GOREN:

Q Doctor, have you had any training in child psychiatry or child psychology?

A No.

Q Have you had any training in general psychiatry or psychology?

A In general psychiatry, I had to take two courses in the New York State Psychiatric Institute in order to be able to work with the population in the cases I'm involved in. In regard to child psychology, while I did not take specific courses in child psychiatry, I was involved in the studies with Loretta Bender and with Franz Kallmann in childhood schizophrenia, the early study that was published in the early 60's—no, the late 50's I believe—in childhood schizophrenia, so I did have that kind of involvement. We were trying to talk about schizophrenia versus autism, and things like that.

Q Okay. How long did those courses in general psychiatry take?

A Well, I cannot tell you precisely. The courses I was involved in involved receiving lectures, and becoming involved in psychiatry at the New York State Psychiatric [22] Institute all the way through my doctoral program, and the doctoral program lasted from June of '49 to 1957,

so it was a long time in growing and birthing, because they didn't know what to do, and so Franz Kallmann insisted I be trained in psychiatry. Joseph Zubin, who is a very well know clinical psychologist in abnormal behavior psychology was chief of abnormal studies at the New York State Psychiatric Institute. He insisted that I be qualified in psychology, so I had to get a qualification in psychology as well as being trained in these kinds of specific psychiatric fields, so I was constantly being pushed by one or the other members of the Ph.D. administrative team to become qualified in their particular area of knowledge, so they would have someone who would work in a mental health, genetics type of thing. It was new entity.

Q Okay. You don't have a medical degree.

A No.

Q Your degree is just in genetics.

A In human genetics—in human variations, which was really human genetics as Columbia University was trying to push this degree out.

Q Okay. Have you ever personally participated in the diagnosis of children?

A Not really, no.

Q Okay. Do you participate, or have you ever participated in decisions to institutionalize children?

[23]

A No.

Q Does your study of classification of schizophrenia and diagnostic reliability also extend to diagnostic reliability of other classifications of mental illnesses?

A It does not. It was aimed particularly at schizophrenia.

Q And you did not study other diagnostic classifications.

A No, I did not.

Q Are you aware of the percentages of children who are presently in Georgia state mental institutions in the various diagnostic categories?

A No.

Q So you don't know if it's a minority of children in Georgia's mental health institutions who have schizophrenia.

A I do not know.

Q Do you think it's possible for psychiatrists to err in diagnosing a child or adolescent as so seriously mentally ill as to warrant his or her institutionalization?

A Yes. I think, as demonstrated in this paper on classification, there is a frequency of misclassification, absolutely.

Q Okay. So errors can occur.

A False positives, and false negatives as well.

Q Okay. And the orientation—

A But that really—I think it's not only in regard to [24] mental illness. This occurs throughout medicine.

Q Are the consequences different?

A The consequences are different according to the disorder that's being diagnosed. For mental illness, it may be improper treatment, which can maintain the patient at the same level as the disorder. Of course, various other

kinds of disruptions for misdiagnosis with regard to cervical cancer—it could have far more direct implications with regard to survival.

Q Okay. In regard to the orientation and training of psychiatrists, does their orientation and training have any effect on their diagnosis of mental illness?

A Absolutely. Different types of orientation result in psychiatrists to diagnose a broad or a narrow view of schizophrenia, and my concern has been with this broad kind of diagnostic schema, and opting for the more narrow diagnostic schema, which is being returned to now.

Q Okay. Depending on the particular psychiatrist's orientation or training, is it possible that persons from two different backgrounds—psychiatrists from two different backgrounds who evaluation a child, that one could diagnose a child a schizophrenic and the other would say that that child is not schizophrenic?

A Surely. But he might say that this child has an emotional disorder, but not schizophrenia.

[25]

Q Okay.

A I think if one wanted to talk about diagnosis of emotional disorder versus non-diagnosis of emotional disorder, I think one would get a greater consistency among psychiatrists, whatever their background, because the emotional disorder category is broad enough to include many types or several types of illnesses, while the diagnosis of schizophrenia, particularly childhood schizophrenia, becomes a far more definitive diagnosis and requires far greater specificity with regard to the kinds of criteria to be included in the diagnostic schema.

Q But even within the same classification of mental illness, is it possible that doctors with different orientation and training would disagree in the severity of the illness?

A That's another question. You're talking about severity.

Q Yes.

A Yes, with regard to severity, absolutely.

Q Okay. In a like manner, are there also different schools of thought in psychiatry which would lend a doctor to one diagnosis that may be different from a diagnosis of someone who is schooled in different thought?

A That's true.

Q Is it possible that the context of a psychiatric evaluation would have an effect on a diagnosis? Let me be more specific.

[26]

A Yeah. Thanks.

Q In a particular setting in which an evaluation takes place, is it possible that the person doing the evaluation may make his diagnosis in accordance with the setting? Let me give you an example. If you walk into a room and you see a book in the waste paper basket, the context in which you see that book might lead you to believe that book is not valuable; however, if you see a book locked away in a case, you might think, in that context, that book is valuable. Okay. In the same manner, when you're evaluating a patient to determine if they have mental illness, does the setting in which the interview takes place, or the setting in which the evaluation is made have an influence on the diagnosis?

A I don't know of any studies demonstrating one or the other side of that kind of an answer. I would hope that it would not. I would assume that there are biases, that individuals have biases, but I would hope that whoever is evaluating the individual and not the setting.

Q Are you familiar with Rosenhan's *On Being Insane in Insane Places?*

A Is that the study published in Science—

Q Yes.

A Of patients that came through with a diagnosis of schizophrenia?

Q Yes. Are you familiar with that?

[27]

A I remember reading the study. I have not read that study in several years. The thing that I do not recall about the study is how long did the individuals remain in the hospital after they were institutionalized.

Q I can show it to you, but if you're not that familiar, we won't go into it.

A I'm not really that familiar with it.

Q Does a single unstandardized interview, the results of which may be augmented by psychological testing, present an adequate sample of a person's behavior from which to make a diagnosis?

A If it's a single, unstandardized interview, which means that it could not have been—could not have been conducted by anyone who is trained, yeah, absolutely.

Q Okay. You're assuming that it could not be done by anyone who was trained.

A I'm assuming that it better be done by someone who is trained. I have much concern about this—about the training—and I think the whole approach of this book here is that with training, you have consistency.

Q Okay. Is it possible that psychiatric judgments may also be influenced by the socioeconomic background of the doctor and the patient?

A It's possible.

Q Is it also possible that the doctor's own personality [28] or value system or self-image or personal preferences can affect a diagnosis?

A That's right, it's possible. You would hope that somewhere in medical education that people learn how to deal with this kind of an issue. I know that people are concerned about this issue, and really very much involved. I know that Dr. Holland, for example, goes through the Grady unit and goes through these units looking specifically for this kind of bias, whether it's conscious or unconscious, because of his concern about it.

Q Do you know if anybody does it in any of the other state institutions?

A I do not know that.

Q The superintendents of the Georgia Mental Health facilities testified that generally they use the Diagnostic and Statistical Manual Number 2 in labeling children and adolescents. Are you familiar with that?

A No.

Q No what?

A No, I'm not familiar with that. I know the DSM. I don't know the contents of these various texts.

Q Okay. Are you familiar with any studies involving criticisms of this manual?

A No.

Q Are you familiar with any of the work of a Dr. Robert [29] Spitzer?

A Yes, very much so. You're talking about his computerized diagnosis.

Q Okay. Well, first of all, I want to talk about a recent paper that he published concerning clinical criteria for psychiatric diagnosis in DSM 3. Are you familiar with that?

A No.

Q Okay. Let me perhaps summarize this for you and ask you if you agree with his point of view in this paper. Let me give a cite for this article. It's in *The American Journal of Psychiatry*, Volume 132, Number 11, November, 1975. Okay. Dr. Spitzer's argument in this article—he describes as having to do with the "well-known generally low degree of reliability of current psychiatric diagnostic practices," and he attributes the sources of this unreliability to four variances: subject variance, occasion variance, information variance and criterion variance. Are you familiar with any of those terms?

A I understand what they mean, yes.

Q Okay. Let's talk particularly about criterion variance. Could you explain what that means to you?

A That the criteria for the diagnosis of the particular disorder that the physician was involved in—what the differences in the criteria were between different physicians.

Q Okay. And do you have an opinion as to how criterion variance may affect diagnosis?

[30]

A Well, with regard to schizophrenia, that issue is taken up in the discussion about the methods of classification and in these studies that were conducted—let me go find it—in the observer agreement and disagreement, because that would be criterion variance among trained interviewers.

Q Okay. Is criterion variance a big factor in reliability of diagnosis of schizophrenia?

A I think it's an important factor. The data suggests that what he said—there is one study in the United States showing average group agreement of 37 per cent. The other four studies range from 53 to 80 per cent, so there is variation based on—certainly, there is no correlation of 100 per cent, or anywhere near that, between one observer and another—trained observer.

Q Okay. On direct examination you were saying that the frequency of reliability of diagnoses—you said at first it can be around 50 per cent, and then could go up between 50 and 85 per cent.

A Yes. That's these numbers.

Q When we're talking about in the range of 50 per cent, are you saying that a diagnosis—that in having psychiatrists agree on a diagnosis, that half the time they're going to agree and half the time they're going to disagree. Is that what you're saying?

A That's 50 per cent, yes. Now, the whole aim of all [31] of these various studies is to deal with this question and to improve on diagnosis.

Q There's seen a need to improve on diagnosis?

A That's the whole point of all medical investigation is to improve on the data that you have now to have it more consistent and more useful.

Q Okay. So the general state of diagnosis now needs improvement; that's what you're saying.

A In all phases of medicine.

Q Okay. In your paper that was introduced into evidence, "Classification in Schizophrenia," which is Defendant's Exhibit Number 2, you state on page 63 that there is some evidence of a high frequency of disagreement in diagnosis.

A That's right.

Q Could you explain what that means specifically?

A You'll have to give me the quote. All right. The statement before that reads, "Almost all of the data suggest, therefore, that with regard to diagnostic concurrence in schizophrenia, reliability is better than chance. There is, however, some evidence of a high frequency of disagreement in diagnosis." That's just to reinforce the statement prior to it, but to say that there is this kind of variation being shown, even though the diagnosis is better than chance.

Q Okay. Are you familiar with the term Kappa coefficient?

A No.

[32]

Q Again, back to Dr. Spitzer. Are you familiar with Dr. Spitzer's article called "Quantification of Agreement in Psychiatric Diagnosis?"

A No. I know Spitzer's material on the computerized mental status examination.

Q This article that I'm referring to is published in *The Archives of General Psychiatry*, Volume 17, July, 1967, and that describes what he says is the Kappa factor. And just to summarize again what his point is in this article, it is that trying to quantify diagnostic reliability, there is a chance factor that has to be accounted for, and the Kappa factor is what he has used to take into account the chance factor in diagnosis. Okay. Did you incorporate this chance factor in your studies?

A No, I did not, because the only—what we looked for in looking for the reports was to have papers—I mean, to look up all papers that were published with regard to diagnosis and consistency of diagnosis in schizophrenia. If it did not deal with that issue, then we did not become involved in the paper. Since this paper is not particularly addressed to schizophrenia, and not addressed to this kind of an issue directly, I did not have the opportunity to read that paper.

Q But isn't it possible that in determining reliability of diagnosis for schizophrenia there—just by chance, psychiatrists are going to agree?

[33]

A The other side of that statement is the findings, and when you go and look at the 18 studies that were published in the 20's and 30's—in the 20 studies that were published in North America, Europe and Asia talking about schizophrenia—not talking about those other 18—they had the same age uncorrected morbidity risks, so whatever these psychiatrists were doing, they're doing it in the same manner, and that's the phenomenon that

so impressed me, because these are different studies than these 18. So there are 38 studies demonstrating consistency.

Q But the studies also didn't take into account the chance factor; is that correct?

A They were just reporting out what the frequency of schizophrenia was in their population under investigation.

Q Okay. Let me backtrack a little. Could you tell us when your study was ready, as opposed to when it was published?

A All right. The original draft of the paper was completed for October of 1973. It was brought up to date before publication in '75.

Q Are you familiar with the types of physicians that are employed by Georgia to work in their mental institutions in regard to their training?

A In regard to their training, no.

Q So you don't know if they're all trained in the same place by the same people.

[34]

A I would assume that they weren't all trained in the same place. That would be an easy assumption.

Q Okay.

A Let me make a statement to follow that one. I think the most important thing about the diagnostic classification is that they present these with the basis for the diagnosis in the medical records of the patient. That's the most important kind of thing.

Q Do you know if they do that?

A Yes. In most medical records one finds this kind of information.

Q Okay. But you don't know from your own personal knowledge this is what's done in Georgia in all of Georgia's mental health institutions.

A No. But I'll tell you one thing that we do know, and it's a peculiar kind of entity. It intrigued me, and I started out with a negative and ended up with a positive. Two psychiatrists, whose names I cannot recall now, and myself went to Milledgeville and did a review of classification for schizophrenia, because we were interested in doing a study along this line, and found that in regard to the classification, there was information in the medical records upon which to base a diagnosis. My concern is is just schizophrenia written across the face sheet of the medical record and is that the basis for the diagnosis, and I was impressed that it was not.

[35]

Q Did you in fact see the records of any children or adolescents?

A My problem is with adolescents, because we weren't looking for children in this study. We were looking for adult schizophrenia. We must have examined some records of individuals 15—you know, in the middle to late teens.

Q But no children.

A No children.

Q Okay. Can you give an opinion as to frequency of reliability which you have described in schizophrenia as compared to transient situational disturbances?

A Absolutely not.

Q You're not familiar—

A I don't know what transient situational disturbances are.

Q Are you familiar with the diagnostic category of unsocialized aggressive reaction of children?

A No.

Q Are you familiar with the diagnostic category of hyperkinetic activity of childhood?

A I'm familiar to the point of having heard it, but I wouldn't want to say I'm familiar more than that.

Q Are you familiar with the category of adjustment reaction of childhood?

A Just to the point of having heard it. I've never done [36] any collection of data or examination of material.

Q Okay. Doctor, one thing in relation to your comments on the involvement of genetics with schizophrenia, what gene can that be found on?

A Well, a geneticist would not view genetic factors in schizophrenia by saying which gene would it be found on. There are 10,000 to 100,000 genes on a chromosome. There are 23 sets of chromosomes. One set is the sex chromosome in the human. There are several investigations, in fact, looking at that linkage with regard to schizophrenia, and there are several studies forthcoming—Elston's study in North Carolina, and the other one—Bartanian, V-a-r-t-a-n-i-a-n (spelling), from Moscow—suggesting that there is linkage between schizophrenia and some other factor. It was very interesting, because this was a presentation by two of these men in a meeting that I had the good fortune to organize in Paris at the International Congress of Human Genetics in 1971, and both these men read

from prepared texts, and each one reported the possibility of linkage, demonstrating linkage between one well known genetic factor and schizophrenia.

Q Okay. Is our state of knowledge in regard to the genetic linkage in schizophrenia complete?

A Oh, no. Just a beginning of the investigations.

Q Okay. Doctor, what I would like to do at this point is just read to you a description of a disorder and ask you [37] your opinion as to what that description—what category—

A I would not consider myself qualified to make diagnoses, and I would not diagnose this. I'm a geneticist involved in mental health genetics, and if anyone were to buy my diagnosis, I would think that they were in a very bad fix. I'll not do it even with regard to Huntington's Disease, where I sit on the international commission.

Q Okay. Then I have no further questions.

MS. KIRKLEY: I have no questions.

[Whereupon, the above-entitled matter was concluded.]

CERTIFICATE

GEORGIA)
)
FULTON COUNTY)

I, Edward H. Lieberman, Certified Court Reporter, do hereby certify that ARTHUR FALEK, Deponent, was by me first duly sworn and the above, pages 1 through 37, is a true and complete transcription of my stenographic notes taken at the said proceedings and was reduced to typewriting by me personally.

I further certify that I am neither of kin nor counsel to any of the parties, nor am I financially interested in the matter.

WITNESS my hand and official seal at Atlanta, Fulton County, Georgia, this the 10th day of December, 1975.

/s/ EDWARD H. LIEBERMAN
EDWARD H. LIEBERMAN

[SEAL]